United States Court of Appeals
for the Second Circuit

JOINT APPENDIX

77-7102, 7114

United States Court of Appeals
FOR THE SECOND CIRCUIT

UNITED STATES COURT OF APPEALS
FILED
MAR 30 197
A. DANIEL FUSARO, CLERK
SECOND CIRCUIT

◆

Docket Nos. 77-7102 and 77-7114

NEW YORK ASSOCIATION OF HOMES FOR AGING, et al.,
Plaintiffs-Appellants,
against

PHILIP L. TOIA, as Commissioner of Social Services
of the State of New York, et al.,
Defendants-Appellees.

◆

JOSEPH BULLA, et al.,
Plaintiffs-Appellants,
against

PHILIP L. TOIA, as Commissioner of Social Services
of the State of New York, et al.,
Defendants-Appellees.

B P/S

JOINT APPENDIX
VOLUME I: Pages 1 to 627

PROSKAUER ROSE GOETZ
& MENDELSOHN
Attorneys for Plaintiffs-Appellants
in Docket No. 77-7102
300 Park Avenue
New York, New York 10022
(212) 593-9000

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for Defendants-Appellees
in Docket Nos. 77-7102
and 77-7114
2 World Trade Center
New York, New York 10047
(212) 488-3391

ANDREW P. ZWEBEN
Legal Services for
the Elderly Poor
2095 Broadway
New York, New York 10023
(212) 595-1340

STEPHEN M. JACOBY
American Jewish Congress
15 East 84th Street
New York, New York 10028
(212) 879-4500

Attorneys for Plaintiffs-
Appellants in Docket
No. 77-7114

PAGINATION AS IN ORIGINAL COPY

INDEX

Page

Relevant Docket Entries viii

Docket No. 77-7102

Complaint, dated November 16, 1976 1

Order to Show Cause, Preliminary Injunction and Temporary Restraining Order, dated November 19, 1976 45

Affidavit of Vicent Massaro in support of motion for preliminary injunction, sworn to November 18, 1976 49

Affidavit of Charles F. Komurek in support of motion for preliminary injunction, sworn to November 18, 1976 54

Affidavit of David Glaser in support of motion for preliminary injunction, sworn to November 18, 1976 58

Affidavit of Dr. Olaf J. Severud in support of motion for preliminary injunction, sworn to November 18, 1976 64

Affidavit of Howard E. Collins in support of motion for preliminary injunction, sworn to November 18, 1976 68

Affidavit of Mitchell Waife in support of motion for preliminary injunction, sworn to November 18, 1976 74

Exhibits to Affidavit of Mitchell Waife in support of motion for preliminary injunction, sworn to November 18, 1976 87

Notice of Motion to Dismiss Complaint, dated November 30, 1976 191

Affidavit of George C. Mantzoros in support of motion to dismiss and in opposition to motion for preliminary injunction, sworn to November 30, 1976 193

Affidavit of Glenn E. Haughie in opposition to motion for preliminary injunction, sworn to November 26, 1976 199

Page

Affidavit of Donald Davidoff in opposition to motion for preliminary injunction, sworn to November 26, 1976 202

Affidavit of William Steibel in opposition to motion for preliminary injunction, sworn to November 30, 1976 206

Supplemental Affidavit of George C. Mantzoros in support of motion to dismiss and in opposition to motion for preliminary injunction, sworn to December 2, 1976 214

Affidavit of Donald Davidoff in opposition to motion for preliminary injunction, sworn to December 1, 1976 219

Supplementary Affidavit of William F. McCann in opposition to motion for preliminary injunction, sworn to December 8, 1976 221

Supplemental Affidavit of Mitchell Waife in support of motion for preliminary injunction, sworn to December 20, 1976 222

Answer, dated January 20, 1977 225

Second Supplemental Affidavit of Mitchell Waife in support of motion for preliminary injunction, sworn to January 31, 1977 234

Exhibits to Second Supplemental Affidavit of Mitchell Waife in support of motion for preliminary injunction, sworn to January 31, 1977 248

Affidavit of Jeffrey A. Mishkin in support of motion for preliminary injunction, sworn to February 7, 1977 499

Notice of Appeal dated February 23, 1977 516

Affidavit of Jonathan M. Brandes, regarding submission to HEW, sworn to February 24, 1977 521

Affidavit of Carmine D. Asparro, regarding Loretto Geriatric Center and Mary Manning Walsh Nursing Home, sworn to March 9, 1977 564

Page

Docket No. 77-7114

Complaint, dated January 26, 1977 576

Order to Show Cause, Preliminary Injunction and Temporary Restraining Order, dated February 7, 1977 610

Affidavit of Harvey Shapiro, M.D. in support of motion for Preliminary injunction, sworn to February 7, 1977 613

Affidavit of Walter Schwartz, M.D. in support of motion for preliminary injunction, sworn to February 7, 1977 614

Affidavit of Anne Morris in support of motion for preliminary injunction, sworn to February 7, 1977 616

Affidavit of Teresa Taliercio in support of motion for preliminary injunction, sworn to February 7, 1977 618

Affidavit of Andrew P. Zweben in support of motion for preliminary injunction, sworn to February 7, 1977 621

Notice of Appeal dated February 23, 1977 628

Affidavit of William H. Frohlich, sworn to February 24, 1977 629

Affidavit of Harvey Shapiro, M.D., sworn to February 24, 1977 646

Affidavit of Walter Schwartz, M.D., sworn to February 24, 1977 649

Affidavit of Anne Morris, sworn to February 24, 1977 652

Affidavit of Teresa Taliercio, sworn to February 24, 1977 654

Answer, dated March 14, 1977 657

Page

Transcripts of Proceedings and Exhibits Marked Thereat

Transcript of Proceedings on December 2, 1976 661

Transcript of Proceedings on December 7, 1976 and exhibits marked thereat 717

Plaintiffs' Exhibit 1: St. Cabrini Nursing Home Financial Statements for 1/1/76 to 9/30/76 924

Plaintiffs' Exhibit 2: St. Cabrini Nursing Home Financial Statements for years ended 12/31/75 and 12/31/74 937

Plaintiffs' Exhibit 3: Hospital memorandum from W. McCann, 10/31/76, attaching schedules listing reimbursement rates for public charge patients in residential health care facilities 958

Plaintiffs' Exhibit 4: St. Cabrini Form HE-2V (Annual Report) for year ended 12/31/75 992

Plaintiffs' Exhibit 5: Loretto Rest Nursing Home Officer's Affidavit of James J. Egan for 12/31/75 Statements 1036

Plaintiffs' Exhibit 6: Loretto Rest Form HE-2V (Annual Report) for year ended 12/31/75 1038

Plaintiffs' Exhibit 7: Mohawk Valley Combined Financial Statements for years ended 12/31/75 and 12/31/74 1113

Plaintiffs' Exhibit 8: Mohawk Valley Profit and Loss Statement for Period Ended 9/30/76 1125

Plaintiffs' Exhibit 9: Margaret Tietz Center Financial Report for 1/1/75 to 12/31/75 1132

Page

Plaintiffs' Exhibit 10: Margaret Tietz Center Form HE-2V (Annual Report) for year ended 12/31/75, with cover letter 1155

Plaintiffs' Exhibit 11: Margaret Tietz Center Financial Report for Period 1/1/76 to 9/30/76 (S.N.F.) and 7/1/76 to 9/30/76 (H.R.F.) 1199

Plaintiffs' Exhibit 12: Daughters of Sarah Form HE-2V (Annual Report) for year ended 12/31/75 1222

Plaintiffs' Exhibit 13: Daughters of Sarah Financial Statement for 1/1/76 to 9/30/76 1253

Plaintiffs' Exhibit 14: Cicero's notes regarding Loretto Geriatric Center, Margaret Tietz, Mohawk Valley, St. Cabrini 1261

Transcript of Proceedings on December 10, 1976 1316

Transcript of Proceedings on December 17, 1977 (morning).. 1403

Transcript of Proceedings on December 17, 1977 (afternoon) and exhibits marked thereat 1448

Defendants' Exhibit X: Cover memorandum dated December 16, 1976 and "Findings of Fact" regarding Loretto Geriatric Center 1601

Defendants' Exhibit X-1: Letter from Harper to Furth, 12/15/76, regarding proposed cuts 1618

Defendants' Exhibit Y: "Findings of Fact" regarding St. Cabrini Nursing Home 1624

Transcript of Proceedings on December 21, 1977 1642

Transcript of Proceedings on December 22, 1977, and Exhibits marked thereat 1685

Page

Plaintiffs' Exhibit 15: Hospital Memorandum from McCann, 10/31/76, attaching schedules listing reimbursement rates for public charge patients in residential health care facilities 1772

Plaintiffs' Exhibit 16: Schedule of Rates - Skilled Nursing Facilities and Health Related Facilities 1807

Transcript of Proceedings on February 4, 1977 1816

Transcript of Proceedings on February 9, 1977, and exhibits marked thereat 1880

Plaintiffs' Exhibit 17: Letter from Department of Health to Loretto, 1/13/77, threatening mortgage foreclosure 2028

Plaintiffs' Exhibit 18: Mary Manning Walsh Nursing Home affidavit 2029

Plaintiffs' Exhibit 19: Letter from Bureau of Budget to Department of Health disapproving appeal of Mary Manning Walsh Nursing Home 2041

Plaintiffs' Exhibit 20: Letter from Elston to Whalen, 1/27/77, returning rate appeals by Mary Manning Walsh Nursing Home and Hebrew Home for the Aged 2045

Plaintiffs' Exhibit 21: Letter from Nurick to Cicero, 12/30/76, submitting group of nonprofit residential health care facilities requiring expedited treatement of appeals......................... 2049

Plaintiffs' Exhibit 22: Letter from Nurick to Cicero, 1/3/77, submitting group of nonprofit residential health care facilities requiring expedited treatment of appeals 2050

Plaintiffs' Exhibit 23: Letter from Nurick to Cicero, 1/7/77, submitting group of nonprofit residential health care facilities requiring expedited treatment of appeals......................... 2051

Page

Plaintiffs' Exhibit 24: Letter from Nurick to Cicero, 1/25/77, submitting group of nonprofit residential health care facilities requiring expedited treatment of appeals 2053

Plaintiffs' Exhibit 25: Letter from Nurick to Cicero, 1/25/77, asking that St. Ann's Home be removed from list 2055

Defendants' Exhibit AA: "Findings of Fact" regarding Mohawk Valley Nursing Home ... 2056

Defendants' Exhibit BB: "Findings of Fact" regarding Margaret Tietz Center for Nursing Care 2071

Defendants' Exhibit CC: "Findings of Fact" regarding Daughters of Sarah Nursing Home 2086

Defendants' Exhibit DD: "Findings of Fact" regarding St. Cabrini Nursing Home 2104

Defendants' Exhibit EE: "Findings of Fact" regarding Mary Manning Walsh Nursing Home 2122

Defendants' Exhibit FF: "Findings of Fact" regarding Loretto Rest Nursing Home 2130

Transcript of Proceedings on February 28, 1977, and exhibits marked thereat 2147

Defendants' Exhibit A: "Findigns of Fact" regarding Beth Abraham Nursing Home 2217

Relevant Docket Entries

Docket No. 77-7102

November 16, 1976	Filed complaint and issued summons
November 19, 1976	Filed plaintiffs' affidavits and order to show cause with temporary restraining order ret. 11/1/76, 3:30 P.M.
December 2, 1976	Filed defendants' affidavit and notice of motion for an order pursuant to Rules 12(b) and (6) to dismiss the complaint, ret. 12/2/76
December 20, 1976	Filed plaintiffs' supplemental memorandum in support of the motion for a preliminary injunction
December 21, 1976	Filed plaintiff N.Y. Association of Homes for Aging, In. supplemental affidavit of Mitchell Waife in support of plaintiffs' motion for a preliminary injunction
January 21, 1977	Filed Answer of defendant to the complaint
January 31, 1977	Filed plaintiffs' second supplemental affidavit of Mitchell Waife in support of plaintiffs' motion for a preliminary injunction
February 2, 1977	Filed plaintiffs' affidavit of Jeffrey A. Mishkin in support of preliminary injunction
February 17, 1977	Filed transcript of record of proceeding dated 12/2/76
February 17, 1977	Filed transcript of record of proceeding dated 12/7/76
February 17, 1976	Filed transcript of record of proceeding dated 12/10/76
February 17, 1976	Filed transcript of record of proceeding dated 12/17/76
February 17, 1977	Filed transcript of record of proceeding dated 12/21/76
February 17, 1977	Filed transcript of record of proceeding dated 12/22/76

February 17, 1977	Filed transcript of record of proceeding dated 2/4/76
February 17, 1977	Filed transcript of record of proceeding dated 2/9/77
February 23, 1977	Filed plaintiffs' notice of appeal to USCA from the order announced on the record on 2/9/77, a transcript which was filed on 2/17/77. Copy to: Louis J. Lefkowitz, Attorney General of the State of N.Y. Eng. 2/23/77

Docket No. 77-7114

February 1, 1977	Filed complaint and issued summons
February 23, 1977	Filed plaintiffs' notice of appeal to USCA from the order denying preliminary injunctive relief to plaintiff as a class made in open court at a hearing on 2/18/77. The portion of the transcript containing the order was filed on 2/23/77. Copy to: Hon. Louis J. Lefkowitz, Attorney General of the State of N.Y. Eng. 2/24/77
March 14, 1977	Filed answer of defendants to the complaint

1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

---X

76 Civ. 5113
(FPG)

COMPLAINT
(Class Action)

Plaintiffs, by their attorneys, Proskauer Rose Goetz & Mendelsohn, for their complaint herein allege:

SUMMARY OF ACTION

1. This is a class action for a declaratory judgment and preliminary and permanent injunctive relief, which seeks to declare illegal and enjoin the new, reduced rates at which the defendants propose to reimburse nonprofit residential health care facilities for services rendered to patients pursuant to the joint federal and state medical assistance program (hereinafter "Medicaid program") provided for under Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq*. (hereinafter "Medicaid Act"). This action

also seeks to declare illegal and enjoin the regulations pursuant to which the challenged rates were calculated. Unless enjoined, defendants will not only enforce the challenged regulations and the new, reduced rates *prospectively*, but will enforce them *retroactively*, by requiring plaintiffs and members of the class to remit to defendants, directly or by set-off, the difference between the challenged rates and the rates at which plaintiffs and members of the class have been reimbursed for services rendered to Medicaid-sponsored patients since January 1, 1976. As more fully set forth below, this complaint is based on the grounds that:

A) The challenged regulations and rates do not, and are not calculated to, provide reimbursement to the plaintiffs and members of the class based on the reasonable cost of rendering services to Medicaid-sponsored patients, as required by the United States and New York State Constitutions and federal and state law;

B) The challenged regulations and rates are, in any event, invalid because the procedures by which defendants have purported to promulgate and implement them do not comply with federal and state law; and

C) Even if the challenged rates and regulations did provide reimbursement of reasonable cost and had been promulgated in accordance with proper procedure, their retroactive application would be illegal under the United States and New York State Constitutions and federal and state law.

2. If the challenged regulations and rates are implemented, the ability of nonprofit residential health care

facilities to provide the essential health services now made available by them to the elderly of this State will be irreparably impaired. If the challenged regulations and rates are implemented retroactively, the demise of members of the plaintiff class will be immediate and thousands of patients for whom they care will be immediatly deprived of essential health services.

JURISDICTION AND VENUE

3. This action arises under the Medicaid Act, the Civil Rights Act of 1871 (42 U.S.C. §1983), Articles I and VI of, and the Fifth and Fourteenth Amendments to, the United States Constitution, Article 1, Section 7 of the New York State Constitution, and the New York State Public Health Law, Social Services Law, Executive Law and Administrative Procedure Act.

4. Jurisdiction is vested in this Court by virtue of 28 U.S.C. §§1331, 1343, 2201, 2202 and principles of pendent jurisdiction. The amount in controversy exceeds the sum of $10,000 exclusive of interest and costs. Venue lies in this District pursuant to 28 U.S.C. §1391.

THE PARTIES

Plaintiffs

5. Plaintiff New York Association of Homes for Aging, Inc. (hereinafter "NYAHA") is a New York not-for-profit corporation whose membership consists of approximately 124 nonprofit residential health care facilities in the State of New York. NYAHA's principal place of business is at 120 West 106th Street, New York, New York.

6. Plaintiff Hospital Association of New York State, Inc. (hereinafter "HANYS") is a New York not-for-profit corporation whose membership consists of approximately 300 nonprofit hospitals and other health care institutions in the State of New York including many hospital-based and free-standing residential health care facilities. HANYS' principal place of business is at 15 Computer Drive West, Albany, New York.

7. Plaintiff St. Cabrini Nursing Home, Inc. (hereinafter "St. Cabrini") is a New York not-for-profit corporation which operates a nonprofit residential health care facility, with its principal place of business at 115 Broadway, Dobbs Ferry, New York. St. Cabrini operates as a skilled nursing facility serving 200 patients. It has been certified in that capacity by the New York Department of Health (hereinafter "Department of Health") as being in compliance with applicable federal Medicaid standards, is a party to a current Medicaid Provider Agreement with the New York State Department of Social Services (hereinafter "Department of Social Services"), and currently provides services to Medicaid-sponsored patients, who account for approximately 75% of its patients.

8. Plaintiff Margaret Tietz Center for Nursing Care, Inc. (hereinafter "Margaret Tietz") is a New York not-for-profit corporation which operates a nonprofit residential health care facility, with its principal place of business at 164-11 Chapin Parkway, Jamaica, New York. Margaret Tietz operates as a skilled nursing facility serving 120 patients, and as an intermediate care facility serving

an additional 80 patients. It has been certified in each capacity by the Department of Health as being in compliance with applicable federal Medicaid standards, is a party to a current Medicaid Provider Agreement with the Department of Social Services, and currently provides services to Medicaid-sponsored patients, who account for approximately 80% of its patients.

9. Plaintiff Mohawk Valley Nursing Home, Incorporated (hereinafter "Mohawk Valley") is a New York not-for-profit corporation which operates a nonprofit residential health care facility, with its principal place of business at 295 West Main Street, Ilion, New York. Mohawk Valley operates as a skilled nursing facility serving 120 patients. It has been certified in that capacity by the Department of Health as being in compliance with applicable federal Medicaid standards, is a party to a current Medicaid Provider Agreement with the Department of Social Services, and currently provides services to Medicaid-sponsored patients, who account for approximately 80% of its patients.

10. Plaintiff Daughters of Sarah Nursing Home Co., Inc. (hereinafter "Daughters of Sarah") is a New York not-for-profit corporation which operates a nonprofit residential health care facility, with its principal place of business at Washington Avenue and Rapp Road, Albany, New York. Daughters of Sarah operates as a skilled nursing facility serving 200 patients. It has been certified in that capacity by the Department of Health as being in compliance with applicable federal Medicaid standards, is a party to a current Medicaid Provider Agreement with the Department of

Social Services, and currently provides services to Medicaid-sponsored patients, who account for approximately 90% of its patients.

11. Plaintiff Loretto Rest Nursing Home Co., Inc. (hereinafter "Loretto") is a New York not-for-profit corporation which operates a nonprofit residential health care facility, with its principal place of business at 700 East Brighton Avenue, Syracuse, New York. Loretto operates as a skilled nursing facility serving 180 patients, and as an intermediate care facility serving an additional 340 patients. It has been certified in each capacity by the Department of Health as being in compliance with applicable federal Medicaid standards, is a party to a current Medicaid Provider Agreement with the Department of Social Services, and currently provides services to Medicaid-sponsored patients, who account for approximately 80% of its patients.

Class Action Allegations

12. Plaintiffs bring this action pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure, on their own behalf and on behalf of all other nonprofit residential health care facilities in the State of New York which provide services to Medicaid-sponsored patients. Approximately 75% of the patients in the nonprofit residential health care facilities which comprise the plaintiff class are Medicaid-sponsored patients.

13. The number of nonprofit residential health care facilities in the plaintiff class is so numerous that joinder of all members is impracticable.

14. There are questions of law and fact common to the plaintiff class. They include, among others, whether certain regulations setting forth Medicaid reimbursement methodologies and the Medicaid reimbursement rates calculated thereunder violate the Medicaid Act, regulations promulgated pursuant to the Medicaid Act, Articles I and VI of, and the Fifth and Fourteenth Amendments to, the United States Constitution, Article 1, Section 7 of the New York State Constitution and the New York Public Health Law, Social Services Law, Executive Law and Administrative Procedure Act.

15. The claims of the representative plaintiffs are typical of the claims of the plaintiff class. The representative plaintiffs will fairly and adequately protect the interests of the plaintiff class.

16. Defendants have acted or refused to act on grounds generally applicable to the plaintiff class, thereby making appropriate injunctive and corresponding declaratory relief with respect to the class as a whole.

Defendants

17. Defendant Philip L. Toia is, and at all times relevant hereto was, the Commissioner of Social Services of the State of New York (hereinafter "Commissioner of Social Services"). Pursuant to the New York Social Services Law, the Department of Social Services is responsible for supervising the administration of New York's medical assistance program under the Medicaid Act.

18. Defendant Robert P. Whalen is, and at all times relevant hereto was, the Commissioner of Health of the State of New York (hereinafter "Commissioner of Health"). Pursuant to the New York Public Health Law, the Commissioner of Health has the duty to promulgate regulations setting forth Medicaid reimbursement methodologies and to determine and certify to the Director of the Budget of the State of New York (hereinafter " Director of the Budget") Medicaid reimbursement rates.

19. Defendant Peter Goldmark is, and at all times relevant hereto was, the Director of the Budget. Pursuant to the New York Public Health Law, the Director of the Budget is responsible for approving the Medicaid reimbursement rates determined and certified to him by the Commissioner of Health.

20. Defendant Hugh L. Carey is, and at all times relevant hereto was, the Governor of the State of New York (hereinafter "Governor"). The Governor is the chief executive officer of the State of New York and, as such, has overall responsibility for the administration of the laws, policies and programs of the State, including the State's medical assistance program under the Medicaid Act.

NEW YORK'S NONPROFIT RESIDENTIAL HEALTH CARE FACILITIES AND THE FEDERAL-STATE MEDICAID PROGRAM

21. Residential health care facilities in the State of New York, commonly referred to as "nursing homes", provide long-term care to elderly residents of the State, which includes a combination of nursing services, life-sus-

taining medical treatment, recreational activities, social services, therapy, lodging and board that is unavailable to such residents from other sources.

22. Depending upon the degree of medical care and services rendered, residential health care facilities are classified as either "intermediate care facilities" (sometimes referred to as "health related facilities") or "skilled nursing facilities".

23. Of the 790 residential health care facilities in the State of New York, 403 are operated for profit, and are sometimes referred to as "proprietary" facilities. The remaining 387, upon whose behalf this action is commenced, are not operated for profit, and are commonly referred to as either "voluntary" or "public" facilities and will be collectively referred to in this Complaint as "nonprofit" facilities.

24. At the present time approximately 40,000 elderly residents of the State of New York are patients in nonprofit residential health care facilities in the State.

25. Nonprofit residential health care facilities were originally constructed with funds provided primarily by private charitable organizations. As the number of elderly citizens in the State of New York increased, and the plight of many worsened, the State recognized that the provision of such services to its elderly citizens was an integral part of the health care which Article 17, Section 3, of the State Constitution required the State to provide to its citizens.

26. Accordingly, in 1966, New York Public Health Law §2851 was enacted, making mortgage money available to nonprofit corporations for the construction of additional residential health care facilities. In enacting that section, the Legislature declared "that a serious shortage of safe and sanitary nursing home accommodations for persons of low income, whose need for combined nursing care, lodging and board cannot readily be provided by the ordinary unaided operations of private enterprise, exists in many communities throughout the state;" and that "it is the policy of the state to promote the provision of such nursing home accommodations...."

27. Pursuant to the policy declared by Public Health Law §2851, and the accompanying provisions of Article 28-A of the Public Health Law, members of the plaintiff class constructed 90 nonprofit residential health care facilities throughout the State of New York, with the approval and financial aid of the State.

28. In 1965 the United States Congress passed the Medicaid Act, which provided for payment of federal funds to states willing to make similar payments for the purpose of furnishing medical assistance to aged individuals whose resources were insufficient to meet the costs of necessary health care. Among the services for which federal funds were made available were the services provided by residential health care facilities.

29. In order for a state to avail itself of the federal funds appropriated under the Medicaid Act, it is first required by Section 1396 of that Act to submit for

approval to the Secretary of Health, Education and Welfare (hereinafter "HEW") a "State plan" for medical assistance which meets the requirements for such plans set forth in Section 1396a of the Medicaid Act.

30. In 1966, the New York Legislature enacted Title 11 of the Social Services Law, Sections 363-369, (hereinafter "Title 11") which, among other things, directed the Department of Social Services to submit a plan for medical assistance on behalf of New York (hereinafter the "New York State Plan"). The New York State Plan was submitted to and approved by HEW in 1966. At all times since 1966 the New York State Plan has provided, among other things, for payment to residential health care facilities for services rendered to Medicaid-sponsored patients. As a result of the adoption of the New York State Plan, and its approval by the Secretary of HEW, the federal government reimburses the State of New York for 50% of the total amount spent by the State for services rendered to Medicaid-sponsored patients.

31. Pursuant to Section 363-a of Title 11, the Department of Social Services is the "single state agency" required by Section 1396a of the Medicaid Act to supervise the administration of the New York State Plan. By virtue of a "Cooperative Agreement" between the Department of Social Services and the Department of Health, the Department of Health is responsible for administering and supervising the medical care and health services available to Medicaid-sponsored patients, including the services provided by residential health care facilities.

32. Pursuant to the New York State Plan, the Medicaid Act and the regulations promulgated by the Secretary of HEW thereunder, in order for a residential health care facility to become eligible for reimbursement for services to Medicaid-sponsored patients it must:

(A) be certified by the Department of Health as being in compliance with the federal Medicaid standards applicable to such facilities, as those standards are defined in 45 CFR §249.33; and

(B) sign a Medicaid Provider Agreement with the Department of Social Services.

33. Pursuant to the terms of the Medicaid Provider Agreement in use in New York State:

(A) the Department of Social Services agrees that it will, for the twelve-month period set forth in the Agreement, make payments for services provided by the residential health care facility to Medicaid-sponsored patients so long as such facility continues to be in compliance with applicable federal Medicaid standards; and

(B) the residential health care facility agrees that it will, in addition to keeping appropriate records and furnishing requested financial information to the Department of Social Services, "not discriminate as to source of payment in admission and retention of patients," an obligation which requires it to accept Medicaid-sponsored patients.

34. In addition to their obligations under Medicaid Provider Agreements, residential health care facilities are required, by New York State regulations, "not [to] discrimi-

nate because of . . . sponsorship in admission, retention and care of patients." 10 NYCRR §§730.2(1) and 740.2(k)

REIMBURSEMENT OF RESIDENTIAL HEALTH CARE FACILITIES FOR SERVICES RENDERED TO MEDICAID-SPONSORED PATIENTS

Federal Provisions

35. The Medicaid Act, as enacted in 1965, did not provide any minimum reimbursement standard for residential health care facilities for services rendered to Medicaid-sponsored patients. Each state was permitted to determine its own reimbursement rates for such services, constrained only by the federal requirement that the rate not exceed certain limits.

36. In cases where a state's rate failed to reimburse residential health care facilities for the full costs incurred in rendering services to Medicaid-sponsored patients, the state plan for medical assistance was permitted to include a "supplementation program", under which additional payments could be secured from a patient's friends or relatives who were not otherwise legally obligated to contribute to the patient's support, or from the patient's own otherwise exempt income or resources.

37. In 1972 Congress amended the Medicaid Act by the addition of 42 U.S.C. §1396a(13)(E), which provided that, effective July 1, 1976, a state plan for medical assistance must provide reimbursement to residential health care facilities "on a reasonable cost related basis...."

38. Concurrent with the effective date of 42 U.S.C.

§1396a(13)(E), the federal regulations permitting supplementation programs were deleted and the last state plan for supplementation of payments to residential health care facilities was scheduled to conclude. All providers of residential health care services in the United States are now required to accept Medicaid reimbursement as payment in full for such services rendered to Medicaid-sponsored patients.

State Provisions

39. At all times relevant hereto prior to March 30, 1976, the reimbursement rates to be paid to residential health care facilities in New York State providing services to Medicaid-sponsored patients were set pursuant to §2807 of the New York Public Health Law.

40. Pursuant to Public Health Law §2807(3), the Commissioner of Health was required to determine such rates and certify them to the Director of the Budget. Prior to the approval of such rates by the Director of the Budget, the Commissioner was required to certify that the rates were "reasonably related to the costs of efficient production of ... [health care] service."

41. In order to assure that the rates set by the Commissioner of Health were, in fact, "reasonably related to the costs of efficient production", Public Health Law §2807(3) directed the Commissioner of Health to take into consideration in determining reimbursement rates "the elements of cost, geographic differential in the elements of cost considered, economic factors in the area in which the...

[facility] is located ... [and] the rate of increase or decrease of the economy in the area in which the ... [facility] is located...."

42. Pursuant to Public Health Law §2807(3), the Commissioner of Health, with respect to all relevant fiscal years prior to the fiscal year beginning January 1, 1976, determined rates in accordance with the methodology contained in rules and regulations codified as Part 86 of 10 NYCRR (hereinafter "Part 86").

The August 1975 Amendments
to the Public Health Law

43. In August 1975, primarily as a result of conditions found to exist in certain proprietary facilities, the Legislature enacted amendments to Article 28 of the Public Health Law, which, among other things, directed the Commissioner of Health to establish criteria for the evaluation of residential health care facilities and directed him to devise, based upon inspections by the Department of Health, a rating system for such facilities "in accordance with the deficiencies and areas of significantly high care and performance which the reports of inspections shall have indicated." (Public Health Law §2803(1)c).

44. Upon information and belief, subsequent to the enactment of the August 1975 Amendments to the Public Health Law, the Commissioner of Health began to devise a system for rating residential health care facilities on the basis of their compliance with the provisions of the State Hospital Code, 10 NYCRR §700 et seq. The inspections to be conducted pursuant to such system, and the ratings to be assigned there-

under, were designed solely to apprise the public of the quality of such facilities and were not designed to determine, and did not take into account, the reasonable costs incurred by the inspected facilities in providing health care services to their patients.

The "Freeze" of Reimbursement Rates at 1975 Levels

45. Pursuant to Public Health Law §2807(4), the Commissioner of Health was required to notify residential health care facilities of their approved 1976 reimbursement rate sixty days prior to the fiscal year for which such rates were effective, i.e., no later than November 1, 1975.

46. On or about October 31, 1975, the Department of Health issued a "Hospital Memorandum" dated October 31, 1975, advising that:

(A) Each residential health care facility has "been directly notified of its Medicaid reimbursement rates for the period January 1, 1976 through December 31, 1976";

(B) "The individual rates for each health facility were developed on an interim basis"; and

(C) "New legislation concerning 1976 reimbursement, and still unresolved aspects of Part 86 . . . have made it impossible to promulgate final health facility rates at this time."

47. In fact, the reimbursement rates of which residential health care facilities were notified in accordance

with the Hospital Memorandum of October 31, 1975 were no more than a restatement of their 1975 rates, the effect therefore being to "freeze" Medicaid reimbursement rates.

48. During the period from the approval of the 1975 reimbursement rates to the time that new rates for 1976 should have been determined, the costs of operating a residential health care facility increased substantially as a result of the general inflationary movement of the economy.

49. Since the 1975 reimbursement rates had been promulgated to reimburse residential health care facilities for their reasonable costs of providing services to Medicaid-sponsored patients during 1975, reimbursing these facilities at those same rates for 1976 Medicaid services necessarily resulted in reimbursement to residential health care facilities of less than their reasonable cost of providing services to Medicaid-sponsored patients, in disregard of the statutory mandate of Public Health Law §2807(3).

50. In an action commenced to challenge the "frozen" reimbursement rates, it was determined that such rates necessarily failed to reimburse residential health care facilities for their 1976 reasonable costs, in violation of, among other things, Public Health Law §2807(3). *Kaye v. Whalen*, N.Y. Sup. Ct. Albany Co. (Staley, J.), decided September, 1976 (appeal pending).

Chapter 76 of the Laws of 1976

51. By Chapter 76 of the Laws of 1976, effective March 30, 1976 (hereinafter "Chapter 76"), the New York

State Legislature attempted to validate the "freeze" imposed by the Commissioner of Health as of January 1, 1976 by providing that in setting rates for 1976 the Commissioner might disregard the requirement of Section 2807(3) of the Public Health Law that rates be "reasonably related to the cost of efficient production" of health care services (Chapter 76, §11).

52. In addition, in an attempt to decrease or at least prevent an increase in the State Medicaid expenditures, Chapter 76 directed the Commissioner of Health to formulate residential health care facility Medicaid rates for the period ending March 31, 1977, which rates would be based upon ratings received pursuant to the rating system the Commissioner of Health had been directed to devise pursuant to the August 1975 amendments to the Public Health Law.

53. On or about March 24, 1976, subsequent to the enactment of Chapter 76 but before the Governor signed it into law, the Commissioners of Health and Social Services advised the Governor's counsel that the rating system being formulated pursuant to the August 1975 amendments was being put into effect but that it would "take a full year before all residential health care facilities are individually rated."

54. Moreover, the Commissioners of Health and Social Services acknowledged to the Governor's counsel that by directing the formulation of reimbursement rates based upon a rating system, without regard to costs, Chapter 76 raised "the possibility that there will be a federal compli-

ance issue as of July 1, 1976 since, as of that date, federal requirements mandate that nursing home rates be formulated on a cost related basis."

55. Notwithstanding the fact that there existed no adequate rating system based on current inspections, and that the rating system that was being implemented was not designed to take into account either intensity of care or the reasonable cost thereof, Chapter 76 was signed into law on March 30, 1976, thereby directing the Commissioner of Health to formulate reimbursement rates in accordance with the rating system.

56. That the purpose of Chapter 76 was to limit Medicaid reimbursement rates is confirmed by the Governor's message, delivered on March 31, 1976, upon approval of Chapter 76. The Governor noted that both the Commissioners of Health and Social Services advised the Governor that they had "serious reservations" about the bill but "the expenditure savings projected under the bill are essential to achieve a balanced budget, and because of the urgent need to present such a budget for the State of New York, I must sign this measure into law."

57. In order to enable the Commissioner of Health to promulgate rates that would become effective prior to the fiscal year beginning January 1, 1977, Chapter 76 (§13) amended Public Health Law §2807(4) so as to permit the Commissioner to give notice of new rates 60 days prior to their scheduled implementation, rather than prior to a particular "fiscal year," as previously provided in Public Health Law §2807(4).

The Use of the Rating System to Limit Reimbursement

58. Between April 1 and May 13, 1976, purporting to follow the directive of Chapter 76, the Department of Health conducted a "crash" program designed to establish "ratings" for every residential health care facility in the state, for the purpose of utilizing such ratings to limit Medicaid reimbursement rates.

59. On or about May 13, 1976, each residential health care facility received a "Nursing Home Rating Certificate", which rated the facility on its "Building Features" and seven types of services:

(A) Nursing
(B) Food-Nutrition
(C) Leisure Time Activities
(D) Cleanliness and Safety
(E) Medical Care
(F) Rehabilitation Therapy
(G) Social Work

60. The ratings were based upon reports of Department of Health surveyors who inspected the facilities, but because the implementation of new rates under Chapter 76 required immediate ratings, the surveys upon which those ratings were based:

(A) were for the most part out of date, and failed in many instances to reflect changes in operations of facilities and corrections of deficiencies, if any, that had occurred between the survey and the rating;

(B) had nothing whatever to do with an analysis of the cost of providing the services rendered, and

(C) were ultimately based upon subjective evaluations of the particular surveyor.

61. The five "ratings" developed by the Department of Health for rating the services inspected were:

(A) "Very Good";

(B) "Good State";

(C) "Good Federal";

(D) "Needs Improvement"; and

(E) "Unacceptable".

62. Although the rating system purported to assign objective criteria -- such as matching performance of the residential health care facility against the standards of the State Hospital Code or the lower (in some cases) standards of the Code of Federal Regulations, the final determination of a residential health care facility's rating was a matter for subjective analysis.

63. For example, the meaning of "Very Good", as formulated by the Department of Health, was as follows:

> "Very Good means - The facility conforms fully with the intent and content of State Hospital Code requirements, provides the type of service being rated by clearly superior methods and with clearly superior results, provides the service efficiently and economically, and is in the vanguard of its class of facilities in the jurisdiction in which located."

64. Upon information and belief, employees of the Department of Health were advised that it was anticipated that only 20 to 30 residential health care facilities, of

all those located in the State, would receive what was ultimately developed as the "Very Good" rating in most or all of the services rated, and that what ultimately was developed as the "Good-State" rating would be "reserved" for those facilities that performed "well above the average" level in any category but that still "could not be documented as furnishing an obviously superior kind of service."

65. Although residential health care facilities were permitted to "appeal" ratings in the individual services received by them on or about May 13, 1976, in light of the subjective criteria involved, the pressure upon the Department of Health to keep ratings from being raised (in order to keep the ultimate reimbursement rates lower) and the absence of adequate provision for hearings to determine appeals from ratings, the appeal process proved an entirely unsatisfactory method by which residential health care facilities could have their services fairly rated.

66. Having developed the rating system as set forth above, and in accordance with the legislative mandate to reduce Medicaid expenditures, the Department of Health proceeded to develop "regulations" designed to relate the rating system to reimbursement rates.

67. Upon information and belief, in devising regulations designed to reduce reimbursement rates, the Department of Health adopted the following approach:

(A) Residential health care facilities were grouped in 5 categories solely according to the number of beds in the facility (the smallest group being 50 beds and under and the largest being over 300 beds). In making such groupings, the Department of Health did not make any attempt to identify facilities whose patient mix was such that a higher degree of medical service was required to care for non-ambulatory patients and therefore declined to follow the previous methodology of Part 86, which grouped facilities by ownership (nonprofit or proprietary), as well as by number of beds and geographical area;

(B) Having grouped the facilities as above, the facilities within each group were further identified by the rating which they received in each of the categories of nursing, food-nutrition, leisure time activities, cleanliness and safety, and social work. For example, all facilities with a capacity of between 100 and 199 beds which received a "Good-State" rating in nursing, were grouped together; and

(C) Having thus identified and grouped the homes by bed size and rating for each service, it was determined what ceiling on reimbursement for each service was required in order to assure that the total expenditure for Medicaid reimbursement for residential health care facilities in 1976 would meet budget requirements predetermined by defendants.

68. The required ceilings on reimbursement were ultimately imposed by subjecting all facilities other than those receiving a "Very Good" rating for a particular service to a ceiling based upon a "percentile system", as follows:

(A) Facilities receiving a "Good-State" rating for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 60th percentile of all facilities in the group.

(B) Facilities receiving "Good-Federal" ratings for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 35th percentile of all facilities which received a "Good-State" rating for such service.

(C) Facilities receiving "Needs-Improvement" ratings for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 25th percentile of all facilities which received a "Good-State" rating for such service.

69. In other words, some part of the actual costs incurred by 40% of the facilities receiving a Good-State rating for any service were disallowed in determining the Medicaid reimbursement for such service, regardless of the reasonableness of the cost incurred in providing the service, the efficiency of its production or the needs of the patients to whom it was provided. Similar exclusions occurred with respect to costs incurred by all facilities above the percentile limitation in each category.

70. Upon information and belief, the particular "percentile" which served as the basis for limiting reimbursement was selected not because it bore any relationship to the reasonable costs of the services provided, but because the ultimate formulation of percentiles yielded the dollar amount to which defendants had determined to limit

total Medicaid reimbursement for residential health care facilities.

71. Upon information and belief, defendants considered -- and rejected -- a variety of higher percentile limitations other than those ultimately chosen, because such higher limitations would not have yielded the predetermined overall Medicaid reimbursement figure to which they considered themselves limited.

Promulgation of the Challenged
Regulations and Rates

72. Upon information and belief, having satisfied himself that the "grouping" and "percentile" limitations described above would yield the desired fiscal results, the Commissioner of Health proceeded to promulgate new regulations, to replace Part 86, embodying the methodology of relating reimbursement to rating and, on September 30, 1976, promulgated "Part 88" of 10 NYCRR, entitled "Reporting and Rate Certification for Residential Health Care Facilities". Part 88 purported to require the calculation of Medicaid reimbursement rates retroactively to January 1, 1976.

73. The Commissioner of Health purported to make the adoption of Part 88 effective immediately, without regard to the 21-day notice period provided for in New York State Administrative Procedure Act §202.2(a), by describing Part 88 as an "emergency" measure permitted to be adopted immediately, pursuant to Section 202.2(c) of said Act. The designation by the Commissioner of Health of Part 88 as an "emergency" measure was purportedly based upon the following "reasons":

A. "The expenditures of the State Department of Social Services currently exceed budgeted amounts for the 1977 fiscal year . . .";

B. "[I]t is imperative that . . . [the] methodology for computing rates for . . . [residential health care] facilities be altered so as to assure fiscal economies immediately"; and

C. "[In] litigation currently pending, a lower court has determined that the current ["frozen"] rates applicable to residential health facilities are invalid insofar as such rates are subject to a statutory mandate which preexisted the authority given in Chapter 76 of the Laws of 1976 and, in order to mitigate the potential threat of such a decision to the general welfare, it is necessary to promulgate this regulation immediately."

74. On October 12, 1976 the Department of Health gave notice of the adoption of Part 86-2 of 10 NYCRR, (hereinafter "Part 86-2"), pursuant to the provisions of the Administrative Procedure Act authorizing promulgation of such rules only after notice and a comment period of 21 days. Part 86-2 is in all material respects the same as Part 88.

75. The 21-day notice provision with respect to the adoption of Part 86-2 expired on November 3, 1976 (November 2 being a legal holiday), and plaintiffs NYAHA and HANYS filed, within the 21-day notice period, a statement with respect to proposed Part 86-2.

76. However, prior to the end of the 21 day notice and comment period, and on or about October 26, 1976,

the Office of the Director of the Budget announced that it had approved "1976 Medicaid reimbursement rates", retroactive to January 1, 1976, certified to it by the Commissioner of Health. It is unclear whether the calculation of such rates by the Commissioner of Health was pursuant to the purported "emergency" measure embodied in Part 88 or pursuant to the provisions of the not-yet adopted Part 86-2.

77. The new rates announced on October 26 produced a total projected 1976 Medicaid expenditure for the State of $2 million less than in 1975, despite the construction and opening of additional residential health care facilities, the expansion of existing facilities, and the increased costs in all aspects of the operation of residential health care facilities.

78. Upon information and belief, the challenged rates, as approved by the Director of the Budget, have been delivered to the local offices of the Department of Social Services responsible for reimbursement, have been or are being mailed to all residential health care facilities in the State of New York, and are now the official Medicaid reimbursement rates for the State of New York.

EFFECT OF THE CHALLENGED RATES

79. Based upon the grouping of residential health care facilities, without regard to degree of medical service provided, ownership or geography, and the application of the subjective rating system and arbitrary percentile system, the rates calculated by defendants pursuant to Parts 83

or 86-2 will reimburse virtually every member of the plaintiff class at far less than its reasonable cost of providing services to Medicaid-sponsored patients.

80. The new rates are in many cases substantially lower than the 1975 "frozen" rates -- which have themselves been held illegal as not properly reimbursing facilities for their 1976 costs. Certain members of the plaintiff class are now scheduled to receive reductions from their "frozen" rates of as much as $20 per patient per day, and even for those members of the plaintiff class not scheduled to receive actual dollar reductions, the proposed new rates fail to take into account increased operating costs and thus fail to reimburse such facilities for their reasonable costs.

81. The prospective impact of the new rates on the individual plaintiffs is representative of the impact on the plaintiff class:

(A) St. Cabrini, serving 200 patients, is scheduled for a reduction of $7.51 (from $62.51 to $55.00) per patient per day.

(B) Margaret Tietz is scheduled for a reduction in its skilled nursing facility, serving 120 patients, of $19.88 (from $71.26 to $51.38) per patient per day and in its intermediate care facility, serving an additional 80 patients, of $6.34 (from $41.42 to $35.08) per patient per day.

(C) Mohawk Valley, serving 120 patients, is scheduled for a reduction of $20.36 (from $49.32 to $28.96) per patient per day.

(D) Daughters of Sarah, serving 200 patients, is scheduled for a reduction of $6.22 (from $50.92 to $44.70) per patient per day.

(E) Loretto is scheduled for a reduction in its skilled nursing facility, serving 180 patients, of $10.70 (from $53.00 to $42.30) per patient per day and in its intermediate care facility, serving an additional 340 patients, of $8.86 (from $36.00 to $27.14) per patient per day.

82. If the proposed new rates are implemented, wholly apart from any retroactive application of such rates, members of the plaintiff class will be unable to meet the costs of operating their facilities and will be unable to continue to provide health care services to their patients.

Retroactive Application

83. Defendants claim that each member of the plaintiff class who has had its Medicaid reimbursement rate reduced is required to remit to defendants, without an opportunity for a prior hearing, the difference between the amount each such facility received pursuant to its prior reimbursement rate and the amount it would have received had the new rate been in effect as of January 1, 1976.

84. Members of the plaintiff class, most of whom lack any reserves to meet unanticipated debts, are now being required to repay defendants enormous sums, with certain facilities owing defendants in excess of $1,000,000. The impact of the retroactive application of the new rates on the individual plaintiffs is representative of the impact on the plaintiff class. If the new rates were applied retroactively from January 1, 1976, as of October 31, 1976:

(A) St. Cabrini would owe approximately $350,000.

(B) Margaret Tietz would owe approximatey $600,000.

(C) Mohawk Valley would owe approximately $600,000.

(D) Daughters of Sarah would owe approximately $350,000.

(E) Loretto would owe approximately $1,200,000.

85. Upon information and belief, defendants intend to withhold prospective Medicaid reimbursement payments to members of the plaintiff class to the extent necessary to "recoup" the amounts now claimed to be owed. If defendants are permitted to withhold prospective Medicaid reimbursement payments, or otherwise to effect the repayment of the amounts claimed to be owed, it will lead to the immediate insolvency of members of the plaintiff class, with the result that thousands of elderly patients in the State of New York will be immediately deprived of essential, life sustaining health care services.

FIRST CAUSE OF ACTION

86. Plaintiffs repeat and reallege the allegation set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

87. Because Parts 88 and 86-2 fail to provide for reimbursement to residential health care facilities for services rendered to Medicaid-sponsored patients on a "reasonable cost related basis", as required by 42 U.S.C §1396a (13)(E), those regulations and the rates calculated pursuant thereto violate 42 U.S.C. §1396a(13)(E) and are invalid thereunder and by reason of the Supremacy Clause of the United States Constitution, Article VI, Clause 2.

SECOND CAUSE OF ACTION

88. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

89. The Medicaid Provider Agreement executed between residential health care facilities and the Department of Social Services constitutes a one-year contract pursuant to which the Department of Social Services is obligated, in consideration of the facility's agreeing to comply with federal Medicaid standards and to accept and render service to all Medicaid-sponsored patients, to reimburse the facility for the reasonable costs of such services.

90. Because Parts 88 and 86-2, and the rates calculated thereunder, do not provide reimbursement to residential health care facilities for the reasonable costs of services rendered pursuant to their Medicaid Provider Agreements, such regulations and rates are in violation of (i) the Medicaid Provider Agreements themselves and (ii) Article I Section 10 of the United States Constitution, which prohibits the enactment of any law impairing the obligation of contracts.

THIRD CAUSE OF ACTION

91. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

92. Because the Medicaid Provider Agreements and the New York Hospital Code (10 NYCRR §§730.2(1) and 740.2(k))

require residential health care facilities to accept Medicaid-sponsored patients, and because CFR §250.30(a)(8) requires such facilities to accept their Medicaid reimbursement as payment in full for services rendered to Medicaid-sponsored patients, residential health care facilities must be reimbursed for the reasonable costs incurred in providing such services.

93. Because Parts 88 and 86-2 and the rates calculated thereunder do not provide residential health care facilities rendering services to Medicaid-sponsored patients their reasonable costs incurred in rendering such services, Parts 88 and 86-2 are in violation of the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and Article I Section 7 of the New York State Constitution.

FOURTH CAUSE OF ACTION

94. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

95. 45 CFR §250.30(a)(7) requires that state plans for medical assistance:

> "Provide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population."

96. Because Parts 88 and 86-2, and the rates calculated do not provide reimbursement to residential health care facilities for the reasonable costs to such facilities in providing care to Medicaid-sponsored patients, Parts 88

and 86-2 are not designed to enlist participation in the Medicaid program, the result of which will be to deprive eligible persons of skilled nursing and intermediate care services which are among the medical services guaranteed to Medicaid-eligible patients under the New York State Plan.

97. By reason of the foregoing, Parts 88 and 86-2, and the rates calculated thereunder, as well as Chapter 76 insofar as it directs or authorizes such regulations and rates, violate the Medicaid Act and regulations, and are invalid thereunder and by reason of the Supremacy Clause of the United States Constitution, Article VI, Clause 2.

FIFTH CAUSE OF ACTION

98. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

99. The Medicaid Act and regulations promulgated thereunder set certain minumum standards for the delivery of residential health care services in states participating in the Medicaid program.

100. Because Parts 88 and 86-2, and the rates calculated thereunder, do not reimburse residential health care facilities for the reasonable costs incurred in rendering services to Medicaid-sponsored patients, such regulations and rates will result in the reduction of services provided by residential health care facilities to eligible patients below the minimum standards for the delivery of such services.

101. By reason of the foregoing, Parts 88 and 86-2 and the rates calculated thereunder, as well as Chapter 76

insofar as it directs or authorizes such regulations and rates, violate the Medicaid Act and regulations and are invalid thereunder and by reason of the Supremacy Clause of the United States Constitution, Article VI, Clause 2.

SIXTH CAUSE OF ACTION

102. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

103. The Medicaid regulations, 45 CFR §246.10(a) (3), require that an approved state plan for medical assistance provide for a "Medical Care Advisory Committee," which "will have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program of the agency."

104. The New York State Plan provides for a Medical Advisory Committee as required by 45 CFR §246.10, and New York Social Services Law §365-c(2) provides that the Medical Advisory Committee "shall advise the Commissioner [of Social Services] with respect to [medicaid] health and medical care services," and requires that the committee meet at least once a year.

105. Upon information and belief, the Medical Advisory Committee has not met within the past year and was not consulted about the adoption or implementation of Parts 88 or 86-2 or the rates calculated thereunder, in violation of 45 CFR §246.10 and New York Social Services Law §365-c(2).

106. By reason of the foregoing, Parts 88 and 86-2 and the rates calculated thereunder are invalid.

SEVENTH CAUSE OF ACTION

107. Under New York Administrative Procedure Act §202.2(c), administrative regulations can be promulgated on an "emergency" basis only if there are adequate reasons supporting a "finding" that "it is necessary for the preservation of the public health safety or general welfare to dispense with the requirements of notice and opportunity to present views."

108. The alleged reasons upon which the Commissioner of Health based the "emergency" adoption of Part 88, including the reason that the state was "threatened" by an adverse decision of a State Court holding the "freeze" illegal (Kaye v. Whalen), provide an inadequate foundation upon which the emergency procedures of the State Administrative Procedure Act may be invoked.

109. By reason of the foregoing, Part 88 was not properly adopted and the reimbursement rates calculated thereunder are invalid.

EIGHTH CAUSE OF ACTION

110. Plaintiffs repeat and reallege the allegations set forth in paragraphs 81 through 85 above, as if more fully set forth herein.

111. Pursuant to §101-a of the New York State Executive Law, before a New York State regulation could become

effective, the Temporary President of the New York State Senate and the Speaker of the New York Assembly must be given at least 21 days notice.

112. Pursuant to New York Administrative Procedure Act §202.2(a), before a regulation such as Part 86-2 could become effective, at least 21 days notice must be given for public comment.

113. The Temporary President of the New York State Senate and the Speaker of the New York State Assembly did not receive 21 days notice prior to the adoption of Part 86-2 and there was no 21 day comment period prior to the adoption of Part 86-2.

114. By reason of the foregoing, Part 86-2 has never been validly promulgated, and the rates calculated thereunder are invalid.

NINTH CAUSE OF ACTION

115. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

116. Defendants have notified all residential health care facilities that the new Medicaid reimbursement rates, which were announced on or about October 26, 1976, are effective immediately.

117. Pursuant to Public Health Law §2807(4), Medicaid reimbursement rates may not become effective until 60

days after the Commissioner of Health notifies each residential health care facility of its reimbursement rate.

118. By reason of Public Health Law §2807(4), the attempt to implement the challenged reimbursement rates prior to 60 days after each residential health care facility is notified of its new rate is invalid.

TENTH CAUSE OF ACTION

119. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

120. Parts 88 and 86-2 purport to be retroactive to January 1, 1976 and the defendants are implementing the rates calculated pursuant to Parts 88 and 86-2 retroactively to January 1, 1976.

121. In applying the rates retroactively, the defendants are requiring those members of the plaintiff class whose new reimbursement rates are lower than the rates at which they have been reimbursed since January 1, 1976, to remit to defendants the difference between the amount each such facility received since January 1, 1976 and the amount which it _would have_ received had the new rates been in effect as of January 1, 1976.

122. In making Parts 88 and 86-2 and the rates promulgated thereunder retroactive to January 1, 1976, the defendants are purporting to act under the authority of Chapter 76 of the Laws of 1976. However, Chapter 76 specifically provides that it "shall not be construed to alter,

change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the enactment of this act." (Chapter 76, §18.)

123. By reason of the foregoing, the attempted retroactive application of Parts 88 and 86-2 and the rates calculated thereunder are invalid under Chapter 76.

ELEVENTH CAUSE OF ACTION

124. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85, and 120 through 122 above, as if more fully set forth herein.

125. Insofar as Parts 88 and 86-2, and the rates calculated thereunder, are retroactively applied, and insofar as Chapter 76 may be construed as authorizing or permitting such retroactive application, Parts 88 and 86-2, the rates calculated thereunder, and Chapter 76 are in violation of the Medicaid Provider Agreements between the members of the class and the Department of Social Services, the due process clauses of the Fifth and Fourteenth Amendments of the United States Constitution and Article 1, Section 7 of the New York State Constitution.

TWELFTH CAUSE OF ACTION

126. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

127. The Medicaid reimbursement rates, of which the members of the class were notified on or about October

31, 1975, were certified by the Commissioner of Health pursuant to the then existing regulations governing reimbursement for residential health care facilities, "Part 86" of 10 NYCRR.

128. Part 86 specifically provided that "no retroactive adjustment will be made in rates certified pursuant to this Part." 10 NYCRR §86.16.

129. By reason of the foregoing, insofar as Parts 88 and 86-2, and the rates calculated thereunder, purport to effect retroactive reductions in the rates certified pursuant to Part 86, they are invalid.

THIRTEENTH CAUSE OF ACTION

130. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

131. Even if Parts 88 and 86-2 were not in themselves illegal, the effect of the retroactive application of the rates calculated thereunder is to penalize plaintiffs and members of the class by requiring the payment of specific sums of money to defendants, based upon a determination that plaintiffs and members of the class failed to meet the criteria upon which the rating system is based.

132. Such penalties may not be imposed without a prior hearing but plaintiffs and members of the class were

not afforded hearings prior to the assessment and enforcement of these penalties.

133. By reason of the foregoing, the retroactive application of Parts 88 and 86-2, and the rates calculated thereunder, is in violation of the due process clauses of the Fifth and Fourteenth Amendments of the United States Constitution and Article I Section 7 of the New York State Constitution.

FOURTEENTH CAUSE OF ACTION

134. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

135. Part 88 and Part 86-2, and the manner in which reimbursement is tied to the rating system, are administrative regulations, legislative in character, which will be upheld only if they are not unreasonable, arbitrary or capricious.

136. The rating system upon which Medicaid reimbursement to members of the class is based depends upon such subjective evaluations as whether the facility conforms with "the intent" of the State Hospital Code, provides the service being rated by "clearly superior methods" and with "clearly superior results," and is in the "vanguard of its class of facilities in the jurisdiction in which it is located."

137. By reason of the foregoing, the rating system is so vague and subjective as to be is unreasonable, arbitrary and capricious, and Parts 88 and 86-2, and the

rates calculated thereunder insofar as they base Medicaid reimbursement upon the rating system, are invalid under the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution, Article 1, Section 7 of the New York State Constitution and the common law of New York State.

FIFTEENTH CAUSE OF ACTION

138. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 85 above, as if more fully set forth herein.

139. Because Parts 88 and 86-2, and the rates calculated threunder, are based upon a methodology that groups facilities solely by number of beds, without regard to geographic location or the degree of care required by the patients in a particular facility, and imposes reimbursement ceilings based upon a percentile system designed solely to limit reimbursement rather than measure reasonable costs, Parts 88 and 86-2, and the rates calculated thereunder, do not rationally relate to the operation of non profit residential health care facilities.

140. By reason of the foregoing, Parts 88 and 86-2, and the rates calculated thereunder, are invalid under the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution, Article 1, Section 7 of the New York State Constitution and the common law of New York State.

141. Plaintiffs have no adequate remedy at law.

142. Plaintiffs and members of the plaintiff class will suffer immediate irreparable injury unless the defendants are preliminarily and permanently enjoined from (i) reducing retroactively the rates calculated under Parts 88 and 86-2, (ii) applying prospectively Parts 88 and 86-2 and the rates calculated thereunder and (iii) reimbursing plaintiffs and the members of the plaintiff class at less than their reasonable costs in rendering services to Medicaid-sponsored patients.

WHEREFORE, plaintiffs pray that:

(1) This Court declare and adjudge that:

(A) The retroactive application of Parts 88 and 86-2, and the rates calculated thereunder, so as to require plaintiffs and members of the class to remit to defendants sums previously paid plaintiffs and members of the class for care to Medicaid-sponsored patients, is in violation of:

(i) The due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and Article 1, Section 7 of the New York State Constitition; and

(ii) The Medicaid Provider Agreements between the members of the plaintiff class and the Department of Social Services.

(B) Parts 88 and 86-2 and the rates calculated thereunder are in violation of:

(i) Section 1396a(13)(E) of the Medicaid Act and the regulations promulgated thereunder;

(ii) The Medicaid Provider Agreements between the members of the plaintiff class and the Department of Social Services;

(iii) Article I, Section 10 and Article VI, Clause 2 of the United States Constitution;

(iv) The due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and Article 1, Section 7 of the New York State Constitution; and

(v) The common law of the State of New York.

(C) Parts 88 and 86-2 are invalid because:

(i) They were promulgated without consultation with the Medical Advisory Committee, in violation of 45 CFR §246.10 and Social Services Law §365-c(2);

(ii) There was no valid basis for the declaration of "emergency" upon which the Commissioner of Health based the immediate implementation of Part 88; and

(iii) The 21-day notice provisions of Executive Law §101-a and Administrative Procedure Act §202.2(a) were not complied with.

(D) The immediate implementation of the rates certified by the Commissioner of Health pursuant to Part 88 or Part 86-2 is invalid because it does not comply with the 60-day notice requirement of Public Health Law §2807(4).

2. This Court preliminarily and permanently enjoin the defendants and their successors, officers, agents, servants, employees and attorneys from:

(A) Applying or attempting to apply Part 38 or 86-2, or the rates calculated thereunder, to any nonprofit residential health care facility for services rendered to Medicaid-sponsored patients.

(B) Attempting to collect, directly or by set-off, any sums of money from nonprofit residential health care facilities with respect to services rendered to Medicaid-sponsored patients at any time prior to the entry of an order or judgment in this action.

3. This Court order the defendants and their successors, officers, agents, servants and employees to compute Medicaid reimbursement rates designed to reimburse plaintiffs and members of the plaintiff class for their reasonable costs in providing services to Medicaid-sponsored patients.

4. Plaintiffs be awarded their costs and such other and further relief as to this Court may seem just and proper.

Dated: New York, New York
November 16, 1976

PROSKAUER ROSE GOETZ & MENDELSOHN

By David J. Stern
David J. Stern
A Member of the Firm
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022
(212) 593-9000

45

Served Nov. 19 [illegible]

Received

Entered in Docket

Entered in Diary [illegible]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York.

Defendants.

---X

ORDER TO SHOW CAUSE WITH TEMPORARY RESTRAINING ORDER

76 Civ. 511[illegible]

([illegible])

Upon the complaint herein, and the annexed affidavits of Mitchell Waife, Howard Collins, Dr. Olaf Severud, David Glaser, Charles Komurek and Vincent Massaro, and upon good cause appearing therefor, it is hereby

ORDERED that defendants, ~~their officers, agents, servants, employees and attorneys~~ appear before this Court in room 128 of the United States Courthouse, Foley Square, New York, New York on ~~November~~ December 1 1976 at 3:30 o'clock in the aftr noon of that day, or as soon thereafter as counsel can be heard, to show cause why an order should not be entered granting plaintiffs' motion for a preliminary injunction pursuant to Rule 65 of the Federal Rules of Civil Procedure, pending final determination of this action, enjoining defendants and their successors, officers, agents, servants, employees and attorneys from:

1. Applying or attempting to apply Part 88 or Part 86-2 of Title 10 of the New York Code of Rules and Regulations, or the Medicaid reimbursement rates promulgated thereunder, to nonprofit residential health care facilities for services rendered to Medicaid-sponsored patients insofar as said Medicaid reimbursement rates effect reductions in the rates at which said facilities are now being reimbursed; and

2. Attempting to collect, directly or by set-off, by retroactive application of Part 88, Part 86-2, or the Medicaid reimbursement rates promulgated thereunder, any sums of money from nonprofit residential health care facilities with respect to previous reimbursement to such facilities for services rendered to Medicaid-sponsored patients from and after January 1, 1976;

and it further appearing to the Court from the pleadings and affidavits annexed hereto that a temporary restraining order preliminary to the hearing for a preliminary injunction should issue enjoining enforcement of Part 88, Part 86-2 or the Medicaid reimbursement rates promulgated thereunder, and the attempt to collect sums of money from plaintiffs and members of the class by retroactive application of said parts and rates; that defendants unless so enjoined will reimburse plaintiffs and members of the class pursuant to Part 88, Part 86-2 and the rates promulgated thereunder at rates lower than plaintiffs are currently being reimbursed for services to Medicaid-sponsored patients, and will attempt to collect sums of money of plaintiffs and members of the class by retroactive application of said Parts and rates and that such enforcement and collection of money will likely occur prior to said date unless restrained by an order of this Court; that the enforcement of said Parts and rates, and the collection of money as aforesaid cause plaintiffs and members of the class immediately and irreparable injury in that it will seriously, irreparably and permanently impair the ability of plaintiffs and members of the class to render residential health care services to residents of New York who are ill, elderly and indigent; and will cause immediate and irreparable injury to such New York State residents; and plaintiffs having made no previous application for the relief requested herein, it is hereby

~~ORDERED that for a period not to exceed ten days after the entry of this order or until November , 1976 at __ o'clock in the ___ noon or as soon thereafter as counsel can be heard, unless this order be dissolved prior thereto or extended then or thereafter, whichever is sooner, defendants, their officers, agents, servants, employees and attorneys be and hereby are temporarily enjoined and restrained pending the hearing and determination of this motion from:~~

~~1. Applying or attempting to apply Part 88 or Part 86-2 of Title 10 of the New York Code of Rules and Regulations, or the Medicaid reimbursement rates promulgated thereunder, to any nonprofit residential health care~~

~~facility for services rendered to Medicaid-sponsored patients, insofar as said Medicaid reimbursement rates effect reductions in the rates at which said facilities are now being reimbursed; and~~

~~2. Attempting to collect, directly or by set-off, by retroactive application of Part 88, Part 86-2, or the Medicaid reimbursement rates promulgated thereunder, any sums of money from nonprofit residential health care facilities with respect to previous reimbursement to such facilities for services rendered to Medicaid-sponsored patients from and after January 1, 1976; and it is further~~

~~ORDERED, that security as required by FRCP 65(c) be waived;~~ and it is further

ORDERED, that personal service of this Order to Show Cause and Temporary Restraining Order together with a copy of the papers upon which it is based upon the New York State Attorney General, and if made on or before 5 o'clock in the after noon of the 22d day of November 1976 shall be deemed sufficient service thereof.

Dated: New York, New York
November 19th, 1976

Issued At
2:15 p.m

/s/
U.S. District Judge

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

---x

76 Civ. 5113

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

VINCENT MASSARO, being duly sworn, deposes and says:

1. I am the Assistant Administrator for Finance of plaintiff St. Cabrini Nursing Home, Inc. ("St. Cabrini") and I submit this affidavit in support of plaintiffs' motion for a preliminary injunction.

2. St. Cabrini is a New York not-for-profit corporation which operates a non profit residential health care facility at 115 Broadway, Dobbs Ferry, New York.

St. Cabrini operates as a skilled nursing facility serving 200 patients. It has been certified in that capacity by the New York State Department of Health as meeting the requirements of a skilled nursing facility under the Medicaid program and, as such, is a party to a current Medicaid Provider Agreement with the Department of Social Services, under which it provides services to Medicaid-sponsored patients, who account for approximately 75% of its patients.

3. As a skilled nursing facility, St. Cabrini provides patients with a full range of skilled health care and related services. These include a combination of nursing services, life sustaining medical treatment, physical therapy, occupational therapy, speech therapy, recreational activities, social services, lodging and board, that is unavailable to its patients from other sources.

4. For calendar year 1975, St. Cabrini's Medicaid reimbursement rate was $62.51 per patient day. I have been advised by counsel that, as of January 1, 1976, the Commissioner of Health was required to calculate a new Medicaid reimbursement rate for residential health care facilities, taking into account the amount by which these facilities' costs increased from 1975 to 1976, as a result of increased labor costs and other inflationary factors. This the Commissioner of Health failed to do. Instead, as of January 1, 1976 St. Cabrini's reimbursement rate and the rates for all other residential health care facilities in the state, were "frozen" at 1975 levels. Obviously, our 1975 rate of $62.51 per patient day, at which we have

been reimbursed during all of 1976 up to the present time would not adequately reimburse St. Cabrini for its 1976 operating costs, which are approximately $65.36 per patient day.

5. On or about November 1, 1976 I learned that the Commissioner of Health had calculated, and the Director of Budget had approved, a new Medicaid reimbursement rate of $55.00 per patient day for St. Cabrini, a reduction of $7.51 per patient day from our already inadequate 1975 reimbursement rate. Under the 1975 "frozen" rates, St. Cabrini's 1976 operating loss to date is $280,000. If the new rates are implemented, in the next two months alone St. Cabrini will lose an additional $120,000 and will be forced to terminate its operations within eight or nine weeks.

6. I have been informed that not only do defendants intend to apply the new reduced rates prospectively, they also intend to apply them retroactively to January 1, 1976. If the new rates are in fact applied retroactively, St. Cabrini will be required to remit to defendants approximately $350,000, which will be accomplished by the withholding of Medicaid reimbursement to St. Cabrini until the amount is recouped.

7. St. Cabrini has absolutely no reserves or other assets which could be used to meet the enormous unanticipated debt which defendants now claim is due. Should defendants seek to effect repayment of this alleged debt, St. Cabrini would be forced immediately to terminate its operations and discharge all 200 of its patients.

8. If St. Cabrini is forced to close, I simply do not know what will become of our patients. While some of the sicker patients may be able to transfer to acute care hospitals, the existing health care facilities in the Dobbs Ferry area do not have a sufficient number of beds available to accommodate the great majority of our patients, many of whom have had strokes or other debilitating diseases and are totally unable to care for themselves.

9. I have been informed that the new, reduced rates at which defendants propose to reimburse St. Cabrini and all other residential health care facilities in the state, were based upon a recently devised "rating system" purportedly intended to measure quality of care. The ratings achieved by St. Cabrini under this new rating system demonstrate that our home is delivering a very high quality of care to our patients. We received ratings of "good-state" (i.e., comply fully with the requirements of the state hospital code) in all relevant categories except "Leisure Time Activities", in which we received an even higher rating of "very good"*. Yet, instead of rewarding this high level of care, the new rates penalize St. Cabrini by reducing reimbursement below even the inadequate 1975 levels and leaving the home on the brink of financial ruin. A rating system which produces such

---

* The definition of a "very good" rating is set forth in the complaint at paragraph 63.

irrational results and so clearly fails to measure reasonable costs, cannot, I am advised by counsel, lawfully be the basis upon which Medicaid reimbursement rates are predicated.

WHEREFORE, I respectfully request that a preliminary injunction be granted to plaintiffs as requested in the complaint.

Vincent Massaro

Sworn to before me this
18th day of November, 1976.

Notary Public

JEFFREY A. MISHKIN
NOTARY PUBLIC, State of New York
No. 31-4507312
Qualified in New York County
Commission Expires March 30, 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

AFFIDAVIT

STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

CHARLES F. KOMUREK, being duly sworn, deposes and says:

1. I am the Director of Finance and Management Information Systems of plaintiff Loretto Rest Nursing Home Co., Inc. ("Loretto") and I submit this affidavit in support of plaintiffs' motion for a preliminary injunction. I am fully familiar with the facts hereinafter stated.

2. Loretto is a New York not-for-profit corporation which operates a nonprofit residential health care facility at 700 East Brighton Avenue, Syracuse, New York. Loretto

operates as a skilled nursing facility serving 180 patients, and as an intermediate care facility serving an additional 340 patients. It has been certified in each capacity by the Department of Health as being in compliance with applicable federal Medicaid standards, is a party to a current Medicaid Provider Agreement with the Department of Social Services, and currently provides services to Medicaid-sponsored patients, who account for approximately 80% of its patients.

3. Loretto's current actual operating costs - after extensive lay-offs and other cuts to reduce expenditures - are $42.14 per patient per day in the intermediate care facility, and $52.78 per patient per day in the skilled nursing facility. Yet defendants now propose to reimburse Loretto for services to Medicaid-sponsored patients at only $27.14 per patient per day in the intermediate care facility, and $42.30 per patient per day in the skilled nursing facility. This represents a reduction from the previous reimbursement rate of $8.86 per patient per day in the intermediate care facility and $10.70 per patient per day in the skilled nursing facility.

4. Loretto currently is in full compliance with the standards for residential health care facilities set forth in applicable federal regulations, as well as the standards set forth in the New York State Hospital Code. However, such standards cannot possibly be maintained under the new, reduced rates. Indeed, the new rates are so far below actual reasonable costs that, under the new rates, Loretto would be required to terminate operations within two months.

5. The average age of the patients at Loretto is approximately 84. Many of these patients are receiving life sustaining treatment and other essential health care. Loretto is the largest residential health care facility in the State of New York outside of New York City and, were Loretto forced to close, the existing health care facilities in the Syracuse area simply could not absorb the additional patients.

6. Loretto has been advised that not only do defendants intend to apply the new reduced rates prospectively, they also intend to apply them retroactively to January 1, 1976. If the new rates are in fact applied retroactively, Loretto would owe the defendants in excess of $1,200,000.

7. Loretto has absolutely no reserves or other assets which could be used even to begin to meet such an enormous unanticipated debt. Should defendants seek to effect repayment of the amount now claimed to be owed, Loretto would be forced immediately to terminate its operations and to discharge all 520 of its patients.

8. I am advised by counsel that the defendants may not legally require the repayment of the amount now claimed to be owed without affording Loretto the opportunity for a prior hearing. Defendants have not, however, advised Loretto that a hearing will be afforded before any action is taken to effect the repayment of the amount now claimed to be owed.

WHEREFORE, I respectfully request that a preliminary injunction be granted to plaintiffs as prayed for in the complaint.

Charles F. Komurek

Sworn to before me this

16th day of November, 1976.

Notary Public

JEFFREY A. [illegible]
NOTARY PUBLIC, State of New York
No. 31-4[illegible]
Qualified in New York County
Commission Expires March [illegible], 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

NEW YORK ASSOCIATION OF HOMES FOR
AGING, INC., HOSPITAL ASSOCIATION OF
NEW YORK STATE, INC., ST. CABRINI NURSING
HOME, INC., MARGARET TIETZ CENTER FOR
NURSING CARE, INC., MOHAWK VALLEY NURSING
HOME, INCORPORATED, DAUGHTERS OF SARAH
NURSING HOME CO., INC., and LORETTO REST
NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential
health care facilities in the State of
New York which render services to
Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social
Services of the State of New York, ROBERT
P. WHALEN, as Commissioner of Health of
the State of New York, PETER GOLDMARK, as
Director of the Budget of the State of
New York, and HUGH L. CAREY, as Governor
of the State of New York,

Defendants.

---X

76 Civ. 5113

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

DAVID GLASER, being duly sworn, deposes and says:

1. I am the Administrator of plaintiff Margaret Tietz Center For Nursing Care, Inc., ("Margaret Tietz"), which is a New York not-for-profit corporation operating a nonprofit residential health care facility in Queens County, New York City. I submit this affidavit in support of plaintiffs' motion for an order preliminarily enjoining defendants from reimbursing Margaret Tietz and members of the

class for services rendered to Medicaid-sponsored patients in accordance with the new Medicaid reimbursement rates calculated by the Commissioner of Health, insofar as these rates are less than the rates at which Margaret Tietz and members of the class have been reimbursed during calendar year 1975.

2. I have had substantial experience in the health-care field. I have been Administrator of Margaret Tietz since October 16, 1972. Prior to that time, in 1971, I was the Administrator of the Rockville Nursing Center in Rockville Center, Long Island. From 1964 through 1971 I was employed at Long Island Jewish Hospital, and was an Assistant Administrator from 1968 through 1971.

3. Margaret Tietz operates as a combined skilled nursing and health-related facility. It has 120 skilled nursing facility beds and 80 health-related facility beds. It has been certified to operate in this capacity by the New York State Commissioner of Health as meeting the requirements of a skilled nursing and health-related facility under the Medicaid program, and as such, is a party to current Medicaid provider agreements with the Department of Social Services under which it provides services to Medicaid-sponsored patients who account for approximately 60% of its patients. It is reimbursed for such services at reimbursement rates calculated by the Commissioner of Health.

4. Margaret Tietz provides its patients with a full range of health-care services. These include a combination of skilled nursing care, life sustaining medical programs, physical therapy, occupational therapy, speech

therapy, recreational activities, social services, lodging and board.

5. As of January 1, 1976, the Commissioner of Health was required to calculate new rates for Margaret Tietz and other residential health-care facilities, taking into account the amount by which these facilities' costs increased during 1975 to 1976 as a result of increased labor costs, and other inflationary factors. This was not done. Instead, as of January 1, 1976, Margaret Tietz's reimbursement rates for its skilled nursing and health-related facility services were frozen at 1975 levels. For the skilled nursing facility patients this was $68.46 per patient day while for the health-related patients it was $41.42 per patient day. Obviously, these 1975 rates at which we have been reimbursed during all of 1976 up to the present time, did not adequately reimburse Margaret Tietz for its 1976 Medicaid costs which are approximately $72.67 per patient day, and $50.36 per patient day for its skilled nursing and health-related facility patients, respectively.

6. On or about November 1, 1976, I learned that the Commissioner of Health had calculated and the Director of the Budget had approved, new Medicaid reimbursement rates for our facility. For our skilled nursing patients this new rate was $51.38 per patient day or more than $17 less than our already inadequate 1975 reimbursement rate. In the case of our health-related patients, we were given two new rates - from January 1, 1976 through August 31, 1976 a rate of $35.08 per patient day and for the rest of 1976, a new rate of $35.64 per patient day. The first of these health-related facility rates is more than $6.00 less than our 1975 rate,

while the second is more than $5.50 less. If our new rates are implemented, Margaret Tietz will be faced with Medicaid loss for the last two months of the year of at least $181,000.

7. I have been informed that the Commissioner of Social Services, who has responsbility for implementing Medicaid reimbursement, intends to implement these rates retroactive to January 1, 1976. If these rates are retroactively applied, Margaret Tietz will be in the position of owing the Medicaid program approximately $600,000 which, I understand, will be recouped by the withholding of future Medicaid reimbursement due Margaret Tietz until the total amount is collected. The retroactive application of these rates will also create a cash deficit for 1976 in excess of $1,000,000 and will leave Margaret Tietz with no alternative but to close immediately.

8. It is my understanding that the reason why Margaret Tietz's reimbursement rates have been so drastically reduced below its actual costs is that the Commissioner of Health has applied, pursuant to Parts 88 and 86-2, various ceilings, tied to ratings, in the computation of these rates. Under these regulations, a ceiling was applied to any cost category in which our facility received less than a "very good" rating.

9. The skilled nursing facility areas of Margaret Tietz were inspected in the latter part of 1975, while the health-related facility areas were surveyed in early January 1976. To the best of my knowledge, Margaret Tietz's ratings, which were determined some time in the late spring of 1976 were based on these surveys. In both the skilled nursing

and health-related facility areas we were rated "Good State" in: "nursing", "food-nutrition", "cleanliness and safety", and "social work". In "leisure time activities" we were rated "Very Good". A "Good State" rating, as I understand it, means that Margaret Tietz meets both the state and federal Medicaid requirements for skilled nursing and health-related facilities. A "Very Good" rating means that we were well above these requirements.

10. We were never given any explanation as to why we were not rated "Very Good" in: "nursing", "food-nutrition", "cleanliness and safety", and "social work". In fact, we never even had an opportunity to meet and discuss our facility with the individuals in the Health Department when they did the rating. As far as I know, they, in fact, have no firsthand knowledge of our facility.

11. Our costs in all categories for which we received a "Good State" rating were subjected to a ceiling and any costs above this ceiling were automatically, and without any regard as to their reasonableness, disallowed in the calculation of our 1976 rate. These costs were disallowed despite the fact that we have never been advised that any of our costs are unreasonable.

12. If Margaret Tietz is forced to close, as it will be if the new rates are implemented, I have no idea where our patients will go. Many of these patients are suffering from serious chronic conditions which require round-the-clock nursing care and medical observation. I fear for their emotional and physical well-being if they do not receive the kind of care that they are presently

receiving from Margaret Tietz. Accordingly, I respectfully request that this court grant plaintiffs' motion for a preliminary injunction.

DAVID GLASER

Sworn to before me this
18th day of November, 1976.

Notary Public

JEFFREY A. MISHKIN
NOTARY PUBLIC, State of New York
No. 31-4507312
Qualified in New York County
Commission Expires March 30, 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

--X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

--X

76 Civ. 5113

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF HERKIMER)

OLAF J. SEVERUD, being duly sworn, deposes and says:

1. I am the Medical Director of the Mohawk Valley Nursing Home, Inc. ("Mohawk Valley"), one of the plaintiffs herein, and make this affidavit in support of plaintiffs' motion for a preliminary injunction.

2. I have been the Medical Director of the Mohawk Valley Nursing Home since November, 1973. Prior to that time, I was employed as Director of the Health Center at Welles College in Aurora, New York (1971 to June, 1973), and I was the Chief of Obstetrics and Gynecology of Mary Imogene Bassett Hospital (from 1946 until 1971), which is affiliated with Columbia University and located in Cooperstown, New York. I graduated from Columbia University Medical School in 1933. I am a Diplomate of the Board of Obstetrics and Gynecology and a Fellow of the American College of Surgeons. I am a member of the Herkimer County Medical Society.

3. As Medical Director for the Mohawk Valley Nursing Home, I am responsible for the day-to-day supervision of the medical treatment rendered to patients in the Home. In carrying out my responsibilities, I work as closely as possible with each patient's private physician.

4. I am intimately acquainted with the medical condition of each of the 120 patients in the Home. It is my opinion that the majority of these patients could not, as a result of their serious medical problems, survive without the type of round-the-clock nursing and other services provided in a skilled nursing facility. For example, 48 of the residents are incontinent; 27 cannot feed themselves at all; 26 have in-dwelling catheters; 69 are severely disoriented; 96 have varying degrees of mental impairment; 18 are diabetic; 12 have open bed sores; and 29 are stroke

patients. Many of the patients, whose average age is between 80 and 81 years old, suffer from more than one of the above conditions.

5. If Mohawk Valley is forced to close as a result of the new Medicaid reimbursement rates, I do not know how most of these patients will be able to obtain the care and treatment which is essential to their survival. There are very few, if any, available beds in the other skilled nursing facilities in the surrounding area.

6. The condition of Mohawk Valley's patients, while serious in most cases, is not of such a nature as would make them eligible for placement in an acute care general hospital. This results from the fact that they are suffering from chronic, debilitating diseases rather than the type of short term acute medical problem for which Medicaid reimbursement is available in a hospital setting.

7. A number of the patients have no living relatives or homes to which they can return. Although some do have living relatives, those relatives are not financially able to provide the round-the-clock nursing and other life-sustaining services necessary for these patients' continued treatment in their homes.

8. Is is my opinion that if these patients are deprived of the skilled nursing services which they are receiving in our facility, that within a short period of time thereafter - i.e. a matter of months - a substantial

number of them will die. Therefore, I believe that it is essential that all steps be taken to insure the continued operation of our facility, including the granting of the injunction sought by plaintiffs.

Olaf J. Severud
OLAF J. SEVERUD

Sworn to before me this
17th day of November, 1976

Ann H. Lister
Notary Public

ANN H. LISTER
NOTARY PUBLIC, State of New York
No. 31-4632716
Qualified in N.Y. County
Commission Expires March 30, 1978

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---x

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

---x

76 Civ. 5113

AFFIDAVIT

STATE OF NEW YORK)
: ss.:
COUNTY OF HERKIMER)

HOWARD E. COLLINS, being duly sworn, deposes and says:

1. I am the administrator of plaintiff Mohawk Valley Nursing Home, Inc. ("Mohawk Valley"), which is a New York not-for-profit corporation which operates a nonprofit residential health care facility in Ilion, New York in Herkimer County. I submit this affidavit in support of

plaintiffs' motion for an order preliminarily enjoining defendants from reimbursing Mohawk Valley and members of the class for services rendered to Medicaid-sponsored patients in accordance with the new Medicaid reimbursement rates calculated by the Commissioner of Health, insofar as those rates are less than the rates at which Mohawk Valley and members of the class were reimbursed during calendar year 1975.

2. I have had a great deal of experience in the field of health care. I have been the Administrator of Mohawk Valley since it opened in 1973 and since January, 1966 I have also been the Administrator of the Mohawk Valley General Hospital in Ilion, New York and from 1961 to 1964 I was the Business Manager of the "Inter-Community Project," which was responsible for the establishment of the Lake Shore Intercommunity Hospital in Irving, N.Y. I am a fellow of the American College of Hospital Administrators and a member of the American College of Nursing Home Administrators.

3. Mohawk Valley operates as a skilled nursing facility serving 120 patients. It has been certified in that capacity by the New York State Department of Health as meeting the requirements of a skilled nursing facility under the Medicaid program and, as such, is a party to a current Medicaid Provider Agreement with the Department of Social Services, under which it provides services to Medicaid-sponsored patients, who account for approximately 80 per cent of its patients, and is reimbursed for such services at reimbursement rates calculated by the Commissioner of Health

4. As a skilled nursing facility, Mohawk Valley provides patients with a full range of skilled health care and related services. These include a combination of nursing services, life-sustaining medical treatment, physical therapy, occupational therapy, speech therapy, recreational activities, social services, lodging and board, that is unavailable to Mohawk Valley patients from other sources.

5. For calendar year 1975, Mohawk Valley's reimbursement rate was calculated by the Commissioner of Health at $49.32 per patient day and Mohawk Valley was reimbursed at that rate during 1975.

6. As of January 1, 1976, the Commissioner of Health was required to calculate a new rate for Mohawk Valley and other residential health care facilities, taking into account the amount by which these facilities' costs increased from 1975 to 1976, as a result of increased labor costs and other inflationary factors. This was not done. Instead, as of January 1, 1976, Mohawk Valley's reimbursement rate, and the rates for all other residential health care facilities in the State were "frozen" at 1975 levels. Obviously, our 1975 rate, at which we have been reimbursed during all of 1976 up to the present time, did not adequately reimburse Mohawk Valley for its 1976 costs, which are approximately $59.13 per patient day.

7. Despite our efforts to contain costs increases, inflation has significantly increased our 1976 expenses over our 1975 expenses, as demonstrated by the following specific items:

Operating Expense	1975* Expense	1976* Expense	% Increase
Insurance	$ 9,258	$10,953	18%
Electricity	20,815	22,264	7
Maintenance Contracts for Elevators	4,453	4,945	11
Food	89,176	95,501	7
Cooking Supplies (other than food)	8,617	10,893	26
Laundry & Linen	7,056	9,418	33

Overall, our operating costs are 9.5% greater in 1976 than they were in 1975.

8. On or about November 1, 1976, I learned that the Commissioner of Health had calculated, and the Director of the Budget had approved, a new Medicaid reimbursement rate of $28.96 per patient day for Mohawk Valley, a reduction of over $20.00 per patient day from our already inadequate 1975 reimbursement rate. If this rate is implemented Mohawk Valley will close within two to four weeks since we will be faced with a cash deficit for the remainder of the year of at least $150,000.

9. I have been informed that the Department of Social Services, which has responsibility for implementing Medicaid reimbursement, intends to implement the rate retroactively to January 1, 1976 in accordance with Parts 88 and 86-2 of the New York Hospital Code. Under a retroactive

---

* Comparisons are between the first 9 months of 1975 and the first 9 months of 1976.

application of the rate, Mohawk Valley will be required to remit approximately $600,000, which will be accomplished by the withholding of reimbursement to Mohawk Valley until the amount is recouped. The retroactive application of the rate will also create a cash deficit for 1976 in excess of $1,000,000. The effect of any retroactive application of the new rate, therefore, will be the immediate closing of Mohawk Valley.

10. I cannot overemphasize the impact that the closing of Mohawk Valley, be it immediate or within the next four weeks, will have on our patients. There are only two other skilled nursing facilities in our geographic area and they are both filled to capacity. While it might be possible to transfer a few of our sicker patients to the hospitals in the area, I do not know where the majority of the 120 patients currently receiving care in the Mohawk Valley Home will go.

11. Many of our patients have had strokes or other debilitating diseases and are totally unable to care for themselves. If they do not receive the continuing care they need -- and can receive only from Mohawk Valley -- it is unlikely they will survive.

12. In all my years in the field of health care, I have never been faced with such a potentially destructive situation -- in terms of human suffering -- as that which

will occur if the new reimbursement rates are permitted to be implemented. Accordingly, I respectfully request that this court grant plaintiffs' motion for a preliminary injunction.

Howard E. Collins
HOWARD E. COLLINS

Sworn to before me this
15TH day of November, 1976

Ann H. Lister
Notary Public

ANN H. LISTER
NOTARY PUBLIC, State of New York
No. [illegible]
Qualified in N.Y. County
Commission Expires March 30, 1973

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

---X

76 Civ. 5133

AFFIDAVIT
(Class Action)

(TPG)

MITCHELL WAIFE, being duly sworn, deposes and says:

1. I am the Executive Vice President of New York Association of Homes for Aging ("NYAHA") and the Administrator of the Jewish Home and Hospital for the Aged. I submit this affidavit in support of plaintiffs' motion for a preliminary injunction.

2. I have read the allegations in the Complaint filed herein, and those are true to the best of my knowledge, information and belief.

The Purpose of Chapter 76

3. Chapter 76 of the Laws of 1976, Parts 88 and 86-2 of the New York Code of Rules and Regulations, and the Medicaid reimbursement rates calculated thereunder, are part of an effort to reduce the total amount of Medicaid reimbursement to residential health care facilities in the State of New York. This is apparent to those familiar with the delivery of health care services in the State of New York -- and has been acknowledged to me by officials of the Departments of Health and Social Services, Division of the Budget and the Governor's Office.

4. Unfortunately, this reduction is sought to be accomplished without regard to the impact which it will have on the ability of nonprofit health care facilities to survive and to render essential life-sustaining services to their patients. I am also advised that the reduction is being made without regard to applicable federal and state requirements that residential health care facilities be reimbursed at the reasonable costs incurred by them in caring for their patients.

5. Upon information and belief, at the time of the enactment of Chapter 76, the Commissioners of Social Services and Health realized that the proposed legislation would not provide reimbursement on a reasonable cost related basis and so advised the Governor's counsel. (P. 2 of Exhibit A hereto, a memorandum from the Commissioners of Social Services and Health to the Governor's counsel.*)

---

*All exhibits to this affidavit are contained in a separate bound volume entitled "Exhibits to Waife Affidavit."

6. The Governor himself recognized the deficiencies in the legislation, since he specifically noted in his message of approval (Exhibit B hereto) the reservations of the Commissioners of Social Services and Health and the obvious deficiencies in the legislation. However, since the legislation was first and foremost a budget bill -- in apparent disregard of the needs of the Medicaid-sponsored patients and the requirements of federal and state law -- the Governor signed the legislation into law.

The Impact of Chapter 76

7. I have read the accompanying affidavits of administrators of other residential health care facilities, detailing the financial impact of the new reimbursement rates upon their individual facilities, and the human suffering that will accompany the cut-backs and closings necessitated if the new rates are implemented. Based upon my knowledge of nonprofit residential health care facilities across the State, and my review of the new rates for all such facilities, I can state that similar situations will occur throughout the State.

8. Under the new reimbursement rates, over 60 per cent of the nonprofit facilities in New York State will receive reductions from their 1975 rates. Since it is now almost 1977, and inflation has increased operating costs throughout the State, reductions to rates below the 1975 rates cannot possibly reimburse facilities for their reasonable costs. This is equally true of those facilities whose rates remain the same as their 1975 rates or who received modest

increases above their 1975 rates. Thus, as far as I can ascertain, with few, if any, exceptions, no nonprofit residential health care facility will be reimbursed for its present reasonable costs under the new Medicaid reimbursement rates.

9. The disaster which the new Medicaid reimbursement rates portend for providers of residential health care services is compounded by the attempt to apply the rates retroactively to January 1, 1976. Parts 88 and 86-2 relate back to January 1, 1976 and the announcement of the new rates indicated that they were effective for the entire year. In attempting to apply the rates retroactively, the defendants will, in effect, cease making current payments for services to Medicaid-sponsored patients until the amounts found to be owing as a result of retroactivity are paid. An example of the treatment of retroactivity is provided by the "Payment Directive" which is Exhibit C hereto. This was sent to the Metropolitan Jewish Geriatric Center from the Ulster County Department of Social Services, with respect to an Ulster County resident who is being cared for by that facility. It indicates that the Department of Social Services computed the amount by which it "overpaid" for the cost of care for the eight months from January through September, by deducting the new, reduced rate from the former rate, and obtained a figure of $1,065. It then determined that for the month of October, under the new rate, the Geriatric Center was entitled to receive $700 for the cost of care attributable to the patient. But, since this amount is $365 less than the $1,065 "overpayment", the Geriatric Center was advised that "no payment will be made

[with respect to the patient] for October's cost of care because of a retroactive rate decrease effective 1/1/76." Obviously, such an approach applied on a statewide basis will deprive residential health care facilities of their ability to meet current expenses and will drive many out of business.

10. I emphasize the financial impact of the reimbursement rates not to demonstrate that our "businesses" are being injured or ruined, since nonprofit residential health care facilities are not "businesses". The injury which flows from the financial impact relates to the suffering that will occur from the attendant cut-backs and closings of facilities.

11. For the vast majority of their patients, nonprofit residential health care facilities are the last home that they will have. Thousands of those patients are receiving life-sustaining treatment. There is simply no place else for most of these patients to go. Even as to those facilities which are not forced to close, the hastily made cut-backs that would be required to permit facilities to continue to exist would endanger care and make a mockery or our attempts to treat the needy aged of this state with dignity, compassion and respect.

12. In order to achieve the purpose of Chapter 76 (i.e. reduce Medicaid expenditures), the methodologies adopted by defendants to calculate new rates, in particular, the subjective rating system, arbitrary "grouping" for rating purposes, and "percentile" limitations of Parts 86 and 86-2, made no attempt to relate the new rates to the actual reasonable costs of operations of nonprofit residential health care facilities.

The Rating System

13. The "rating system" which Chapter 76 directed to be applied to residential health care facilities for purposes of calculating reimbursement was, from its inception, unrelated to measuring the costs incurred by facilities in rendering the particular type of care required by their patients. I know this from my own knowledge of the rating system and have been so advised by representatives of the Department of Health who developed the rating system.

14. In October, 1975, when the rating system that was ultimately tied to reimbursement by Chapter 76 was being formulated, a memorandum reflecting the criteria to be used was prepared by the Department of Health, and is Exhibit D hereto. As page 3 of Exhibit D indicates, the "highest" rating was to be given only if:

A. The "patients [are] treated with dignity and respect . . .";

B. "[T]here [is] a general atmosphere of hope and cheer;"

C. "[P]atients [are] doing things they find interesting and stimulating;" and

D. "[P]atients look forward to each new day."

15. The criteria for specific services to patients were only slightly less subjective. For example, the health inspectors, in "rating" a facility for its nursing services, were directed to determine whether "each resident [is] given the type of care he needs", and whether the resident's relatives and physicians are "kept informed" of his condition and progress. In judging food and nutrition, the health inspectors were directed to determine

whether meals were "well prepared and attractively served." In judging leisure time activities, the health inspectors were to determine whether "interesting" activities and outings were provided. (Exhibit D,pp. 1-2)

16. Obviously, Medicaid reimbursement could not be based on such criteria, and when these criteria were developed, in late 1975, there was no intention to apply them to reimbursement. Instead, the ratings developed by them were simply to be posted in each facility, in an attempt to give the public some information about the atmosphere and quality of particular facilities -- information that the Legislature felt was required in light of public disclosure of abuses in certain propietary facilities.

17. As developed, the ratings were to be implemented upon the basis of surveys to be conducted by the Department of Health, and were "intended to be the simplest possible and clearest statement that can be made about what the profile is of each of the facilities major patient care end products." (Exhibit E, p. 4)

18. As of March, 1976, when the Legislature enacted Chapter 76, the "rating system" discussed above, as limited as it was in its scope, was not yet in effect. As the Commissioners of Social Services and Health advised the Governor (Exhibit A , p. 2), the "rating system is being put into effect, but it will take a full year before all residential health care facilities are individually rated." Nevertheless, the Governor signed Chapter 76 into law, with its direction that the Commissioner tie reimbursement to the rating system that was being developed, and

calculate Medicaid reimbursement rates on such a basis immediately.

19. The chaos that followed was inevitable. Upon information and belief, all or most residential health care facilities in the state received a "rating" within six weeks of the enactment of Chapter 76. Those ratings were based upon inspections conducted, in some cases, well over a year earlier. Of course, the inspections and surveys upon which they are based were never intended to provide a basis for reimbursement.

20. Unfortunately, the arbitrariness and subjectivity of the rating system was only one-half of the problem which residential health care facilities were to face under Chapter 76. The Governor's message of approval of Chapter 76 indicated that "the expenditure savings projected under the bill are essential to achieve a balanced budget." (Exhibit B .) I have been advised, and therefore state upon information and belief, that those in the Department of Health who are responsible for implementing the rating system and tying it to reimbursement were told that they were expected to limit Medicaid reimbursement in 1976 to the 1975 levels. Accordingly, if very high ratings were to result in reimbursement of a facility's reasonable costs, there was a built-in requirement that not too many facilities receive the rating which would permit such reimbursement.

21. In order to accomplish this end, the criteria that were developed after Chapter 76 was enacted contained built-in subjective factors to minimize the number of facilities that would receive ratings enabling them to obtain full reimbursement.

22. For example, a facility was entitled to full reimbursement of its costs for a particular service only if it received a "Very Good" rating. The definition of "Very Good" (which is contained in Exhibit F hereto) is set forth in paragraph 63 of the complaint, but bears repeating in full here:

> "Very Good means - The facility conforms fully with the intent and content of State Hospital Code requirements, provides the type of service being rated by clearly superior methods and with clearly superior results, provides the services efficiently and economically, and is in the vanguard of its class of facilities in the jurisdiction in which located."

23. Although I am not certain who was responsible for giving each facility its final rating, I believe that this was done by an employee of the regional office of the Department of Health, together with the surveyor or inspector who visited the facility (assuming that the inspector was still employed by the Department of Health at the time the rating was given). What necessarily resulted was a situation where Health Department representatives were attempting to assign ratings on the basis of stale inspections, not intended to relate to reimbursement and conducted under a different proposed rating system. They did all this against a standard seeking to determine whether the facility provides a service "by clearly superior methods" and is "in the vanguard" of its class of facilities.

24. As it turned out, in "nursing", the reimbursement category which accounts for over 50% of reimbursable costs tied to rating, only 22% of the nonprofit facilities in the state received a "Very Good" rating, and thereby became entitled to receive full reimbursement for their nursing costs.

25. The next highest rating which a facility could receive was "Good-State", which was judged as meaning that "the facility conforms at least minimally with state hospital code requirements." (Exhibit F, p. 2.) Thus, if a facility met every single requirement of the state hospital code it would still not receive a "Very Good", which required it to conform "fully with the intent and content of state hospital code requirements."

26. The distinction between "Very Good" and "Good-State" is vital, since it was ultimately determined that in computing rates 40% of all facilities receiving "Good-State" rating would have some part of their actual costs in providing the service so rated eliminated from their reimbursement rate. In other words, the "ceiling" applied to any service which received "only" a "Good-State" rating was the amount spent by the facility at the 60th percentile of "Good-State".

Groupings and Percentiles

27. Parts 88 and 86-2 (Exhibits G and H hereto) provide the methodology by which the "ratings" are applied to limit reimbursement. It establishes certain "ceilings" for reimbursement, depending upon the rating given, but in attempting to group facilities for purposes of applying the ceilings, facilities were grouped only by size. For example, a residential health care facility of 150 beds was limited, in the case of a "Good-State" rating, to the 60th percentile of all facilities in the 100-199 bed category.

28. In the past, facilities had also been grouped by ownership (nonprofit versus proprietary) and by geography

(the state was divided into seven regions). The grouping by ownership had the effect of grouping voluntary facilities only with other voluntary facilities. The significance of this is that such facilities necessarily incurred greater costs than "proprietary" facilities since they have a much sicker patient population than do proprietary facilities. As the Department of Health itself found, in a report issued in 1975, there are far fewer discharges from voluntary facilities to hospitals than there are from proprietary facilities to hospitals. (A copy of the report is annexed as Exhibit I .) Because of the intensity of care required for sicker patients, voluntary facilities hire more registered nurses (as opposed to practical nurses) and generally have larger medical and supporting staffs. While there is no ceiling on reimbursement for medical treatment per se, the costs attendant upon the provision of such treatment -- additional space, etc. -- increase dramatically the over-all operating budget for the facility. Nevertheless, in determining the 60th percentile, nonprofit and proprietary facilities are harder hit by the ceilings than are proprietary facilities providing a lower intensity of care.

29. On the matter of failure to group by geography it should be obvious to anyone -- especially the Department of Health, which recognized the obvious in prior years -- that geography plays a large role in cost. The price of a particular item generally is more expensive in New York City that it is in other regions of the state, but no recognition was given to this fact by the methodology of Parts 38 and 86-2.

30. The percentile limitations which were ultimately imposed under the methodology set forth in Parts 88 and 86-2 were selected for the purpose of limiting overall reimbursement. In other words, there was no attempt to relate the "percentile" to the reasonable, valid costs incurred by facilities in rendering the care required by their patient mix. Instead, those responsible for setting percentile limitation used that percentile -- particularly in the "Good-State" limitation -- which would guarantee that Medicaid reimbursement for 1976 would not exceed reimbursement for 1975. Upon information and belief, the Department of Health considered using percentile limitations of 75% and 80% for "Good-State" ratings, but abandoned these percentiles because the actual dollar reimbursement would have been higher than the 1975 total reimbursement.

31. Perhaps, if the Department of Health was not under the enormous time pressure to issue Parts 88 and 86-2 immediately, it could have developed methodologies, groupings and percentiles which attempted to compensate for the deficiencies of the scheme mandated by Chapter 76. In fact, the Department of Health had so little time, that it attempted to promulgate Part 88 as an "emergency" measure, and thereby eliminate the need for the 21-day notice and comment procedure required for such regulations. A copy of the "emergency" message is annexed as Exhibit J.

32. The ultimate result has been regulatory chaos. The new Medicaid reimbursement rates vary from facility to facility and grouping to grouping in a manner that is

without rationality. The only connection among all of the reimbursement rates is that they uniformly fail to pay to nonprofit residential health care facilities their reasonable costs in caring for Medicaid-sponsored patients. Accordingly, I respectfully request that plaintiffs' motion for a preliminary injunction be granted.

MITCHELL WAIFE

Sworn to before me this
18th day of November, 1976.

Notary Public

JEFFREY A. MISHKIN
NOTARY PUBLIC, State of New York
No. 31-4507312
Qualified in New York County
Commission Expires March 30, 1977

NEW YORK ASSOCIATION OF HOMES FOR
AGING, INC., et al.,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of
Social Services of the State of New
York, et al.,

Defendants.

EXHIBITS TO WAIFE AFFIDAVIT

EXHIBIT A

STATE OF NEW YORK
DEPARTMENT OF HEALTH

MEMORANDUM

March 24, 1976

89

To: Judah Gribetz, Esq.

From: Robert P. Whalen, M.D.
Philip L. Toia

Subject: Issues with regard to Budget Bill (S. 7287-A and A. 9257-A)

You have asked that we supply you with a preliminary analysis of potential problems in the bill recently enacted by the legislature relating to emergency controls of expenditures under the medical assistance and home relief programs (S. 7287-A; A. 9257-A). The following is a list of such questions.

1. Bill section 8 amends subdivision one of section 2803 of the Public Health Law by adding thereto a new paragraph (d) which provides that the Commissioner of Health shall "determine the necessity and appropriateness of care and services provided by hospitals and home health agencies to individual patients."

✓ ✓

The Commissioner is required to "adopt necessary rules and regulations including but not limited to those for determining the necessity of admission, controlling the length of stay, the provision of surgery and other services, and the methods and procedures for making such determinations."

These provisions are in conflict with the requirements of section 1151, Part B of Title XI of the Social Security Act which provides that such determinations will be made by PSRO's. Bill section 8, therefore, raises serious questions of Federal preemption of the duties assigned to the State Commissioner of Health and State compliance with Federal requirements for participation in Titles XVIII and XIX of the Social Security Act.

Additionally, it is highly questionable whether the staff which would be necessary to administer the requirements of the new section would be eligible for federal financial reimbursement under present federal requirements.

Two options are available: 1) take on the PSRO's and find out who has the ultimate authority, or 2) modify the various provisions to speak in terms of scope of benefits actions, rather than medical necessity. Option 2 appears to be the better course of action.

90

2. Bill section 8 also amends subdivision 2 of section 2803 of the Public Health Law. The amendment to subdivision 2 requires the State Hospital Review and Planning Council to establish "minimum acceptable standards" consistent with Federal requirements. It also provides that existing State standards "shall be deemed to constitute maximum standards . . ." for "purposes of limiting medical assistance reimbursement".

NOT DON

Bill section 11 requires that rates of payment be formulated in accordance with the provisions of sections 2808 and 2803 of the Public Health Law. The rating system developed pursuant to the provisions of section 2803 will be substantially altered by the provisions of bill section 8. Bill section 11, together with bill section 8 will make ~~the~~ prompt formulation of rates of payment extremely difficult.

min. max

3. Bill section 11, among other things, adds a new paragraph (e) to Public Health Law section 2807(2). As drafted, paragraph (e) is very difficult to administer.

The second sentence of (e) directs the Commissioner to formulate rates for residential health care facilities "in accordance with" sections 2803(1)(c) and 2808. That is, such rates must take into consideration the rating provisions of 2803(1)(c) and the prudent buyer and quality of care provisions of 2808.

The 2803(1)(c) rating system is being put into effect, but it will take a full year before all residential health care facilities are individually rated.

Under 2808, we can tie quality of care to rates. We can evaluate facilities and work those evaluations into the rate making process. But, it is difficult to use the specific rating categories and other details of 2803(1)(c) at this time, especially as compounded by the "mini-maxi" provisions discussed above.

In addition, bill section 11 raises the possibility that there will be a Federal compliance issue as of July 1, 1976 since, as of that date, federal requirements mandate that nursing home rates be formulated on a cost related basis. To the extent that bill section 11 requires that costs be disregarded, the compliance issue could be raised.

If possible, a chapter amendment should be sought which would delete the reference to section 2803(1)(c) in paragraph (e).

This proposal will not defer implementation of 2803(1)(c) at all -- it simply uncouples the requirement from the January 1, 1976 - March 31, 1977 rate process.

If such a revision can not be accomplished, the spirit can be followed, but there will be serious question as to our following the letter of the law.

4. Bill section 15 prohibits the granting of Home Relief assistance for single persons under 21 years of age and living apart from a legally responsible relative until the completion of legal proceedings to enforce the support obligations of such relative (i.e. the entering of an order of disposition). The deletion of the maximum grants for one and two person households at the SSI level and the substitution of this new provision together raise substantial problems that may result in increased, rather than decreased, expenditures.

The deletion of the maximum grant provision could have serious fiscal consequences beyond and apart from the proposed legislation. In the Abramowitz and Mahonev cases (Abramowitz, et al. v. Lavine, et al., 74 C. 1773 [USDC: EDNY]; Mahonev, et al., v. Dumpson and Berger, Index # 41452/75 [Supreme Ct., N.Y. County, Appellate Div. - 1st Dept.], S.S.I. recipients have asked that the State be required to provide supplemental Home Relief benefits where a person's H.R. budget deficit would be greater than the S.S.I. flat grant level. Should the State lose these cases, which may have been avoided had the administration's original proposal been adopted, it will result in an estimated $50 million in Home Relief costs in addition to the savings that could have been directly realized from the imposition of the maximum grant.

The intent of the substitute provision relating to Home Relief eligibility for persons under twenty-one was to allow the State to realize the savings, in whole or in part, that were lost as a result of the deletion of the maximum grant provision. It is doubted that such savings will actually result, since this entire provision can be expected to be attacked in court immediately upon implementation. Since Home Relief can be provided only to those persons who are not eligible for any other form of assistance, the persons applying for Home Relief who are subject to this provision will have absolutely no source of income during the pendency of the family court proceeding. Because of this harsh result, a plaintiff will have an excellent chance of success in such a case on the grounds that the requirement is unreasonable and arbitrary and that it unlawfully discriminates on the basis of age.

Therefore, the language contained in the original bill should be reinstated.

✓ 5. Miscellaneous technical corrections - Even assuming that the provisions added by the legislature are allowed to stand, a number of technical corrections would be desirable in order to clarify intent or to make the provisions possible to administer. The following are mentioned as illustrative of the types of amendments necessary and are not intended to constitute an exhaustive list:

ABORTION

✓ a) Bill section three was changed by the legislature to "clarify" language relating to second opinions for deferrable surgical procedures to assure that emergency surgery would not be subject to a second opinion requirement. Unfortunately, the specific exclusion of emergency surgery from the second opinion provision raised the implication that surgery "meeting standards for surgical intervention" (including medically necessary abortions) is intended to be subject to the second opinion requirement. The language should be further clarified to specifically exclude surgery "meeting standards for surgical intervention".

b) Bill section 7 prohibits final Medicaid payments for benefits covered by Medicare unless Medicare claims have been "filed and denied." This provision should be modified by 1) clarifying that it applies only to care for persons eligible for Medicare, 2) clarifying that the denial can be "in whole or in part," thereby allowing Medicaid to pick up portions of cost not covered by Medicare, and 3) clarifying the intent of the word "denial" to indicate whether denial is effective upon rejection by the fiscal intermediary, whether available avenues of appeal need be pursued, etc. > not nec.

6. Two provisions of the bill as originally introduced deserve special consideration for inclusion in any chapter amendments that may be developed. These provisions are:

The authority of the Budget Director to suspend the policy of allowing exceptions to the 20-day maximum stay limitation. While it is clear that the State has the power to enact a flat maximum length of stay without an exception policy, it is equally clear that substantial abuse of the exception policy would result in the total inability of the State to realize savings from this provision. Authority to suspend the exception policy in cases of substantial abuse is highly desirable, whether the mechanism for suspension be an exercise of emergency powers by the Budget Director, the Health Commissioner or some other public authority, and even though the exercise of the power be made subject to some type of administrative or legislative review.

p.4
already
approve
only if
[illegible]
type or
[illegible]
[illegible]

The involvement of the Hospital Council in the rate promulgation process. The original Budget bill made it clear that the Health Commissioner would have sole responsibility for the promulgation of reimbursement rules. The purpose of this provision was to allow for immediate changes in rules without the delays occasioned by Health Council review.

A chapter amendment might succeed if a specific time limit were added (1/1/76 - 3/31/77) and if the Commissioner was required to give notice of proposed rules to the Council.

It is noted that the major administrative problems discussed above would fall to the Health Department under their present responsibilities. The major concern that the Department of Social Services will have with implementation of the bill will be that the notification to local districts of new rates, and of determinations of necessity and appropriateness of care, forwarded in a timely and orderly manner. Because of the complexity of the provisions added by the Legislature and the very short implementation period allowed, Social Services will encounter great difficulty in achieving effective implementation, particularly without the advantage of a Medicaid information and claims processing system.

Please > [illegible]

[illegible] 977-2778 → Thanks.

EXHIBIT B

can be given
nation is need-
njuries in this
nade as to the

attributable to

is no less real
out states that
fering are dis-
be misused by
aintiffs.
fidual may re-
more informa-
al malpractice
actment of my
e awards will
carefully an-
on of a limita-

set-off of all
cases.
issues. First,
ndividual who
f time, includ-
an employ-

medical mal-
the benefit of
benefits would
injury cases.
ved the intro-
receipt by the
of this legis-
which will be
n the basis of

dation, which
is necessary

ds in medical
ss of $50,000.
practice cases
would thereby
ts in all other

bstantial basis
medical mal-
th the report
perience with
t may result."
oposal is war-

he New York
vise and Con-
aw and Rules

GOVERNOR'S MEMORANDA APPROVAL OF BILLS

MEDICAL ASSISTANCE AND HOME RELIEF PROGRAMS—EXPENDITURES—EMERGENCY CONTROLS

On approving L.1976, c. 76, the Governor stated:

March 31, 1976

This bill is a substantially amended version of my original Budget Bill submitted both in the Special Session last year and again early in this Session. It has been changed by the Legislature in virtually every major respect, and as a result, both the Commissioner of Health and the Acting Commissioner of Social Services have advised me that they have serious reservations about the bill. In addition, the Regional Director (Region II) of the Department of Health, Education and Welfare has written to express the Department's concern over certain provisions in the bill.

The expenditure savings projected under the bill are essential to achieve a balanced budget, and because of the urgent need to present such a budget for the State of New York, I must sign this measure into law. I do so, however, with reluctance and with a determination to put before the Legislature in the near future a number of proposed changes designed to meet the objections raised by the Departments of Health and Social Services and to insure that the Medicaid program in this State can be effectively and fairly administered.

The bill is approved.

Hugh L. Carey

EXHIBIT C

DEPARTMENT OF SOCIAL SERVICES
COUNTY OFFICE BUILDING
KINGSTON, N.Y. 12401
Telephone 331-9300

TO ALL NURSING HOMES

Re: Payment Directive

(1) All vouchers should be returned no later than the 10th of the month, which will be paid on the 20th of the month.

(2) Vouchers returned after the 10th of the month will be processed with the next months vouchers and payment will be made approximately on the 20th of the following month.

(3) PLEASE make all adjustment notices and corrections on a separate sheet of paper when returning signed voucher.

DO NOT WRITE ON FINANCIAL VOUCHER.

No payment will be made on Dora Ostrich for October's cost of care because of a retroactive rate decrease effective 1/1/76.

Old Rate	$ 846.00					
New Rate	773.00					
	73.00	x	2 months	=	$ 146.00	Jan. & Feb.
Old Rate	$ 882.00					
New Rate	773.00					
	109.00			=	109.00	March
Old Rate	$ 908.00					
New Rate	773.00					
	135.00	x	6 months	=	810.00	April - Sept.
			Total Overpayment	-	$1,065.00	

10/1-31/76	Cost of Care	$ 773.00	
LESS	Resources	72.20	
		700.80	
LESS OVERPAYMENT		1,065.00	
		364.20	to be applied towards

EXHIBIT D

HOW RESIDENTIAL HEALTH CARE FACILITIES ARE RATED

New York State Health Department rating is based on a thorough, detailed inspection and evaluation of the:

* quality of care provided
* training and competence of staff
* suitability of building and equipment
* efficiency of daily operation
* variety of programs and services offered
* medical condition and well-being of patients
* general atmosphere
* patient morale

A Health Department Survey team spends an average of 3 to 5 days on the premises observing conditions and procedures; talking with staff, patients and relatives; examing records and files.

WHAT HEALTH INSPECTORS CHECK

1. Nursing

__Is adequate staff employed?

__Is staff trained in working with elderly patients?

__Is each resident given the type of care he needs?

__Are physicians and relatives kept informed of resident's condition and progress?

2. Food-Nutrition

__Are meals well prepared and attractively served?

__Do meals include the right foods to provide all daily nutritional requirements?

__Are special diets prepared for residents when necessary?

3. Leisure Time Activities

__Are interesting activities and outings provided?

__Are activities geared to different cultures, interests and capabilities of residents?

__Are all residents, who are able, encouraged to join activity programs?

__Is adequate space, equipment and material provided for activity program?

4. Cleanliness and Safety

__Is building clean and in good repair?

__Are water, sewage, heating and air-conditioning systems working properly?

__Is food cooked, served and stored in a sanitary way?

__Are precautions taken to control spread of infection?

__Are fire-safety and accident-prevention procedures carried out?

5. Medical Care

__Are physicians' orders carefully recorded and carried out?

__Are patients examined by their physicians regularly?

__Are physicians kept informed of their patient's condition?

__Is prompt emergency physician service provided?

6. Rehabilitation

(Occupational, Physical, Speech and Hearing Therapy)

__Is appropriate staff, equipment and space provided for each service?

__Is each patient helped [illegible] attain and maintain his highest level of physical capability?

__Are therapy programs reviewed periodically to make sure each patient is progressing at his highest level?

101

7. Social Work

__Are trained social workers available to help patients and families with personal problems?

__Do social workers confer with nursing staff in developing a total plan of care for each patient?

8. Building Features

__Is the general atmosphere pleasant and cheerful?

__Are patient rooms comfortable, with adequate space and privacy?

__Are there adequate bathroom and toilet facilities?

__Is sufficient space provided for dining, recreation and visitor meetings?

IMPORTANT NOTE

"YES" answers on all the above questions does not necessarily mean high quality care. The highest rating is given only when the following is true.

__Are patients treated with dignity and respect by all employees?

__Is there a general atmosphere of hope and cheer?

__Are patients doing things they find interesting and stimulating?

__Do patients look forward to each new day?

Ratings are based on findings at the time of the last inspection of this facility by the Health Department. Conditions may have changed for better or worse since then. State law and regulations require each facility to correct any shortcomings, whenever they are found, within a reasonable time limit.

Anyone knowing of unsatisfactory conditions or practices at this facility should notify the nearest office of the New York State Department of Health immediately. Favorable comments are welcome at any time.

Call Collect - Health Care Hotline - (518) 457-7390

Regional Office ________________________

Regional Health Director______________

EXHIBIT E

DEVELOPMENT OF A RATING SYSTEM FOR RESIDENTIAL HEALTH CARE FACILITIES

/‾Nursing Homes (SNF's) and Health Related Facilities (ICF's)_7

in NEW YORK STATE

The requirements of 2803.1(c) (effective September 1, 1975) of Article 28 of the Public Health Law are set forth below.

> "The commissioner shall promulgate and publish uniform criteria for the evaluation of residential health care facilities with respect to their compliance with the standards set forth in this section, as indicated by the results of the inspections conducted pursuant to the provisions of this section. Such criteria shall include a detailed listing of the types, and degree of severity or unacceptability, of deficiencies which inspections might indicate, and shall also indicate areas of care and performance in which residential health care facilities notably and significantly exceed required minimum standards. In promulgating such criteria, the commissioner shall devise a system of rating residential health care facilities in accordance with the deficiencies and areas of significantly high care and performance which the reports of inspection shall have indicated. Such system shall include no less than five specific rating categories. The rating assigned to each residential health care facility on the basis of its immediately prior inspection shall be deemed a part of the results and findings of that inspection,"

The above requirements must be viewed in light of the provisions of 2803.1(a) and (b) which call for two or more inspections annually of each RHCF. The departmental policies and the agreements with the authors of the legislation are that all inspections will be unannounced and that the inspection system will consist of three components. One will be the full on-site inspection as to facility conformance with pertinent provisions of the State Hospital Code and with applicable Federal Title XVIII and/or XIX regulations. This will include the mandated fiscal audit set forth in 2803.1(b). The second component will include all of the necessary followup visits to secure plans of corrections of deficiencies and to ascertain progress toward or completion of correction of deficiencies found.

The third component will be medical review visits (PMR or IPR, as appropriate) to determine the quality of care being received by individual patients or residents. These medical review visits and the information obtained therefrom will be expanded to assure that all aspects of care incorporated in the rating system will be covered.

The first and second components are beamed essentially at examining provider capability of furnishing services. The third, Medical Review-type visit focuses on provider performance or output and attempts to quantitate and qualitate the end product--the quality of care received by patients or residents.

2803.1(c) also must be viewed in light of two other important 1975 amendments to Article 28. One is the system of penalties for continuing violations which must be adopted by the State Hospital Review and Planning Council as additions to the State Hospital Code as set forth 2803.6 and 7 (see pages 24 and 25 of the reassembled version of Article 28).

The other are provisions 2808.1(a), (b) and (c) which require the commissioner to promulgate interim regulations governing rate setting for related health care facilities for a period extending no later than December 31, 1976 and to submit recommendations to the Governor and the Leaders of the two Houses of the State Legislature no later than February 1, 1976 on what form the rate setting laws, regulations and system should take in the future. Both the interim regulations and the Commissioner's recommendations to the Executive and Legislative Branch of Government must "relate the rate of payment for each residential health care facility to the operation and program management of the facility as well as the quality of patient care provided by the facility" (see pages 43 and 44 of the reassembled Article 28).

In my original review of and comments on 2803.1(c) it seemed clear to me that a number of important relevant factors must be considered in developing the required rating system. In the meetings of the Central Office Task Force and then the combined Central Office-Regional Office Task Force these factors were re-identified and agreed to as being vital considerations.

Ten factors or criteria have been considered and taken into account, hopefully, in preparation of the proposed rating system. These are:

1. The rating system document must be uncomplicated, concise, clear and readily understandable.

2. The words used in this document must have meaning to the least informed and the least literate person who reads it. The words and terms cannot include professional jargon.

3. The five or more items on which each facility is rated must include only those more important aspects of operation that are significant to patients, their relatives and interested parties. For example, to the patients or residents it is the food they receive that is important--not the rather complex system for getting it to them.

4. The ratings assigned must describe the end product received by patients and therefore must focus on the quality of the services. Accordingly, it must emphasize performance or output more than capability or capacity.

5. The ratings assigned, therefore, must express medical review findings (PMR/IPR)--component No. 3 of the survey system--though not at the expense of excluding important findings from component Nos. 1 and 2. Accordingly, medical reviews should be conducted within a reasonable period of time in relation to the promulgation of the rating system findings. From several months before to several after the major on-site inspection (component No. 1) should be considered.

6. The rating system and its promulgation also must tie in with the narrative summary of deficiency findings made and amended during the 90-day inspectional-correctional cycle (component Nos. 1 and 2 of the survey process).

7. The rating system should not and cannot reward large facilities having complex and sophisticated services simply because these facilities are large and their services complex and sophisticated. Nor should such system punish small, uncomplicated facilities simply because they are small and can offer fewer, less complicated services. To wit, the large facility accepting and caring for quite sick patients should not be rewarded if it cannot fully meet the needs of these patients. The small facility accepting and caring principally for a less sick and more ambulant patient "mix" and performing quite well in doing so should be well rated.

Thus, the ultimate measure is the comparison of what the patients or residents in each facility need vs. what they actually receive. Tie in with the proposed Patient Assessment system for long term care facilities will be necessary.

8. The rating assigned to each of the items set forth in each facility's profile must be documentable and documented professionally. It must be capable of standing up in hearings and court, if necessary. Therefore, there must be backup criteria or subsets of information obtained from all three components of survey process. These backup materials and documentations can be in professional jargon and can be as detailed as necessary. To the fullest extent possible, the information should be available from the Article 28 (and Federal) survey forms and the medical review forms and findings.

9. The rating assigned each facility must tie in eventually to the rate of payment set for it. The new interim formula required to be promulgated by the Commissioner and used not beyond December 31, 1976 must take into account the rating system and the findings made in connection therewith. The Commissioner's proposals to be made to Executive and Legislative branches by February 1, 1976 also should include reference to the tie-ins with the rating system.

10. The RHCF rating system and documents should be used by survey offices as part of their long run strategies with each facility. This document also should be useable by and useful to each facility as part of its own self-improvement program ("Operation Bootstrap").

In developing this system the Task Force also decided that the assigned rate should be expressed either in numerical scores or letter grades of the kind most commonly used in all levels of the educational system. The A, B, C, D, F letter grade was selected.

Consideration was given to assigning relative value numerical scores to each of the patient care services considered for inclusion in the facility rating profile (e.g., for a nursing home, nursing care might be assigned 25 points, activities and food 20 each, and the remaining services lesser amounts accordingly for a total of 100 points). For the time being this notion of relative value rating has been set aside.

The Task Force originally agreed that seven basic patient care elements of a nursing home's operations should be included in the profile. These were nursing, food, activities, environment, physician care, rehabilitation therapies and social services. Because of the importance of room space, privacy, adequate dining areas, and suitable space for leisure time activities, it was decided to add a rating of the suitability of the building itself as an eighth item in the profile.

The Task Force agreed that those facilities that were substantially in conformance with all the important requirements of the State Hospital Code (at the end of the 90-day cycle) but that gave little evidence of more than barely meeting the requirements could be assigned letter grade "C."

Those facilities that continue to have correctable deficiencies that were not considered hazards to health and safety at the end of the 90-day cycle should be assigned letter grade "D" in whichever of the eight items profiled the deficiency persisted.

Any facility continuing to have one or more deficiencies that are considered hazardous to health and safety in any of the eight profiled items should be assigned letter grade "F" for that item.

Letter grade "A" in any particular item profiled should be given only if the facility furnishes that particular service in clearly superior fashion and does so efficiently, economically and effectively. It might be anticipated that only 20 or 30 facilities of the entire 600 nursing homes, for example, could be rated "A" in most or all eight items profiled.

The "B" rate would be reserved for those facilities that performed well above the average or "C" level in any item but that still could not be documented as furnishing an obviously superior kind of service.

Certain tie-ins with the rate setting system are being considered. For example, facilities rated "D" in any of the eight items profiled probably should be subjected to the penalty imposing provisions of 2803.6 and 7.

Any facility scoring "F" in any of its eight characteristics could be subject to an automatic 10% reduction in its Medicaid rate for whatever period the hazardous deficiency continued to exist and for not less than thirty days.

Facilities with one or more services in category "A" might be allowed to exceed whatever ceiling might be set for that particular portion of their cost of operation--providing it could be documented that the superior service (or services) is (are) being delivered efficiently, economically and effectively.

The subset criteria still are in developmental process--as is the one-page rating document itself. Both are subject to change based on input from field personnel and from the experiences gleaned in using these documents. Conversion of professional jargon terminology in the rating system document to the clearest and most readily understood of lay terminology remains to be done. Suggestions from the field are sought eagerly and will be seriously considered.

In conclusion, the rating system, at this stage of development, is intended to be the simplest possible and clearest statement that can be made about what the profile is of each of the facilities major patient care end products. It is not intended to supplant in any way the information obtained for the purpose of surveillance and provider agreements nor medical review. It is not intended that other elements of the facility's operation are to be excluded from consideration in developing the rating. Judgements as to facility administration and management, the provision of pharmaceutical services, the operation of infection control committees, and utilization review are made and can be made elsewhere for other purposes. It is expected that deficiencies in any of these areas would have their impact on one or more of the eight profiled services in the rating system. Nevertheless, it is eminently clear that the final rating system document and the ratings assigned in accordance therewith must be kept as simple and as understandable as is feasible.

It is hoped that this background explanation will help clarify the purposes and development of the rating system to its present stage and that it will help allay some of the misunderstandings and anxieties that the document alone, without background information, may raise.

George M. Warner, M. D.
Chairman, Task Force - Rating System

EXHIBIT F

Instructions for Assigning Ratings

Overall Rating

Very Good means - all eight types of service are rated "Very Good".

Good-State means - at least four specific services (Nursing, Food-Nutrition, Leisure Time Activities and Cleanliness and Safety) or more of the eight services rated are rated "Good-State", the facility does not exceed any other State requirement and the facility conforms fully with all other Federal requirements.

Good-Federal means - at least four specific services (Nursing, Food-Nutrition, Leisure Time Activities and Cleanliness and Safety) or more of the eight services rated are rated "Good-Federal", the facility conforms minimally with all other Federal requirements and the facility does not exceed any State requirement.

Needs Improvement means - one or more of the types of service is rated at but not below the "Needs Improvement" level

or

one or more non-rated types of service has been documented at the "Needs Improvement" level, a penalty has been or is being imposed and an authorized notation of same is being made in "Remarks" on the Rating Certificate.

Unacceptable means - one or more of the types of service is rated "Unacceptable"

or

one or more non-rated services has been documented at the "Unacceptable" level, a penalty has been or is being imposed and an authorized notation of same is being made in "Remarks" on the Rating Certificate.

Conditional means - the facility has been penalized during the rating year, an authorized notation of same is being entered in "Remarks" and the facility at the time of rating is not being rated at the "Needs Improvement" or "Unacceptable" level. The term "Conditional" is to be used to prefix the rating being assigned.

Deferred means - the facility is in litigation with the State on a conformance with standards or related issue and cannot be rated until the issue is resolved and the litigation completed.

Individual "Type of Service" Rating

Very Good means - The facility conforms fully with the intent and content of State Hospital Code requirements, provides the type of service being rated by clearly superior methods and with clearly superior results, provides the service efficiently and economically, and is in the vanguard of its class of facilities in the jurisdiction in which located.

Good-State means - the facility conforms at least minimally with State Hospital Code requirements.

Good-Federal means - the type service being rated conforms with one or more Federal requirements that are less than or lower than State requirements.

Needs Improvement means - the facility has one or more documented continuing deficiencies that, singly or in combination, are not actual or imminent hazards to health and safety of patients and the facility has been or is being penalized for the deficiency(ies).

Unacceptable means - the facility has one or more documented continuing deficiencies that, singly or in combination, are actual or imminent hazards to health and safety of patients and the facility has been or is being penalized heavily for the deficiency(ies).

BEST COPY AVAILABLE

EXHIBIT G

PART 88

REPORTING AND RATE CERTIFICATION FOR RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, §2808)

Section 88.1 Definition. As used in this Part, the term "residential health care facility" shall be deemed to include all facilities or organizations covered by the term "nursing home or health related facility" as defined in Article 28 of the Public Health Law, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and where

required, has been established by the Public Health Council.

88.2 Financial and statistical data required. (a) Each residential health care facility shall complete and file with the New York State Department of Health and/or its agent annual financial and statistical report forms supplied by the department and/or its agent. Residential health care facilities certified for title XVIII (medicare) shall use the same fiscal year for title XIX (medicaid) as is used for title XVIII. All residential health care facilities must report their operations from January 1, 1977 forward on a calendar year basis.

(b) Financial and statistical reports required by this Part shall be submitted to the department and/or its agent no later than 120 days following the close of the fiscal period. Extensions of time for filing reports may be granted upon application received at least 15 days prior to the due date of the report and only in those circumstances where the residential health care facility established, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a residential health care facility fails to file the required financial and statistical report on or before the due dates, or as the same may be extended pursuant to paragraph (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day

of the calendar month following the due date of the required report and continuing until the last day of the calendar month in which said required report is filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the Department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) A cost report must be filed in accordance with this section by each new facility for the first six month period during which the facility has had an over-all average utilization of at least 90 percent of bed capacity. This report must be filed and properly certified within 60 days following the end of the six month period covered by the report.

88.3 Uniform system of accounting and reporting. Residential health care facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health. Records shall be maintained by residential health care facilities in accordance with the appropriate section of the State Hospital Code. Rate schedules shall not be certified by the Commissioner of Health unless

residential health care facilities are in full compliance with all reporting requirements.

88.4 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorize specific variation in such principles.

88.5 Accountant's certification. The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish. The requirements of this Section shall not apply to residential health care facilities operated by units of government of the State of New York.

88.6 Certification by operator or officer. The financial and statistical reports shall be certified by the operator or an officer of the medical facility.

88.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted of the records of residential health care facilities, in a manner to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (medicare-medicaid and other organizations and agencies having audit responsibilities) to

satisfy the department's auditing needs.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department. This limitation shall not apply to situations in which fraud may be involved.

(d) Residential health care facilities shall be given 30 days after the mailing of notification of audit findings to appeal such findings, by submitting data intended to justify the facility's position in the areas of disagreement. Failure by the residential health care facility to reply to such findings within the 30 day period, or to receive from the department an extension of time for reply shall be considered as acceptance of the findings.

(e) Rate revisions resulting from audit findings may be made retroactively to the period or periods during which the rates based on the periods audited were established.

(f) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions.

88.8 Patient days. (a) A "patient day" is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

88.9 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies pursuant to this part shall be for the rate period beginning January 1, 1976 and ending March 31, 1977.

88.10 Computation of basic rate. (a) Basic rates shall be computed on the basis of allowable fiscal and statistical data submitted by the residential health care facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs shall be made.

88.11 Ceilings on allowable costs for reimbursement purposes.

(a) For the purpose of establishing allowable cost ceilings for determining reimbursement rates effective January 1, 1976 for governmental payments, skilled nursing facilities and health related facilities will be grouped separately with respect to size as indicated in (1) below and with respect to the service ratings received for those functions indicated in (i) through (v) in (2) below and by size only with respect to (vi) in (2) below:

(1) Size of facilities

(i) 50 beds and under
(ii) 51 to 99 beds
(iii) 100 to 199 beds
(iv) 200 to 299 beds
(v) over 300 beds

(2) Functions

(i) Nursing
(ii) Food-Nutrition
(iii) Leisure Time Activities
(iv) Cleanliness and Safety
(v) Social Work
(vi) Administration

(b) Allowable costs for reimbursement for any function for which a facility receives a "Good - State" rating may not exceed the 60th percentile of the perdiem range of costs as reported for the base year by all facilities receiving a "Good - State" service rating for that rated function within the size groups as indicated in (a) (1) above.

(c) Allowable costs for reimbursement for any rated function for which a facility receives a "Good - Federal" service rating may not exceed the 35th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(d) Allowable costs for reimbursement for any rated function for which a facility receives a "Needs Improvement" rating may not exceed the 25th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(e) Allowable costs for reimbursement for any rated function for which a facility receives an "Unacceptable" rating may not exceed the 10th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(f) Ceilings will not be imposed on costs for any rated function for which a facility receives a "Very Good" service rating.

(g) Allowable per diem costs for administration may not exceed the 50th percentile of the range of per diem costs reported for the base year for all facilities within the size groups indicated in (a) (1) above.

(h) In establishing the ranges of per diem costs, by function, facilities will be grouped without regard to sponsor or geographic area. An economic leveling factor developed on the basis of area salaries will be used to make the costs comparable.

(i) Any amount to be eliminated in accordance with this section in determining reimbursement rates will be equal to the excess of the total per diem costs computed from the total costs reported in the base year for the functions in (a) (2) above over the total of the functional ceilings established for the service ratings and administration of the facility.

88.12 Adjustments to basic computed rate.

To the allowable basic rate, computed in accordance with ceiling limitations, and prior to the addition of capital costs, realty leases, return on net equity capital, and leases, depreciation and interest related to equipment there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a residential health care facility's cost shall be weighted based on a sampling of data by the following categories:

(i) Salaries and employee health and welfare expense to be computed based on a total of sub-weights.
(ii) Nonpayroll administrative and general expense.
(iii) Nonpayroll household and maintenance expense.
(iv) Nonpayroll dietary expense.
(v) Nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United

States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(4) During the rate period, the cost indicators used in determining the projection factors in establishing the current certified rates may be compared with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health, as of mid-point in the rate period. Based upon such review the Commissioner may, in his discretion either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

88.13 Final rates. Rate adjustments may be made to correct errors in the determination of rates.

However, errors resulting from submission of information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the commissioner's rate computation sheet. Errors resulting rom the rate computation process may be corrected if brought to the attention of the commissioner within four months of receipt of the commissioner's rate computation sheet.

88.14 Revisions in certified rates. (a) The State Commissioner of Health may consider only those applications for prospective revisions of certified rates which are based on

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a residential health care facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 88.13;

(3) significant increases in the over-all operating costs of a residential health care facility resulting from the implementation of additional programs, staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the facility by the Commissioner;

(5) requests for waivers of any provisions of Part 88 for which waivers may be granted by the Commissioner as prescribed in specific sections; and

(6) changes in the method of providing services which result in a lower over-all cost for the services provided;

(7) requests for relief from the ceiling provisions of this

part. For such relief, a residential health care facility must demonstrate that its range of approved services, patient mix, lengths of appropriate stays or other pertinent factors are direct causes for all or part of the costs in excess of the ceilings. Such relief shall not result in a rate which exceeds that based on maximum reimbursable State standards, unless a waiver of such standards is granted by the Commissioner. If relief is granted, the resulting revised rates shall become effective as of the first day of the rate period.

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(d) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the Commissioner shall notify the requesting party of his determination.

(e) In reviewing appeals for revisions to certified rates the Commissioner may refuse to accept or consider an appeal from a residential health care facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital and Planning Council in one of its facilities;

(3) where it has been determined by the Commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

In such instances subdivision (c) of this section shall not be effective until the date the appeal is accepted by the Commissioner.

(f) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(g) Any residential health care facility eligible for title XVIII (medicare) certification providing services to patients insured under title XVIII which is not, or ceases to be, a title XVIII provider of

care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

88.15 Rates for residential health care facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

(a) The usual and customary rates, for comparable services, in the geographic area.

(b) Satisfactory cost projections.

(c) Allowable actual expenditures.

(d) An anticipated utilization of no less than the average for the geographic area or the minimums established in this Part, whichever is greater.

88.16 Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.

88.17 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Part, or in accordance with specific determination by the Commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII (medicare) program.

(b) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII (medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the Commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the Commissioner, as to allowable costs in the computation of reimbursement rates shall be published in a hospital memorandum or other appropriate manner.

(f) Allowable costs shall not include costs not properly related to patient care or treatment which principally afford diversion, entertainment or amusement to owners, operators or employees of residential health care facilities.

(g) Allowable costs shall not include any interest charged related to rate determination or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(h) Allowable costs shall not include the direct or indirect costs of advertising, public relations or promotion except in those instances where the advertising is specifically related to the operation of the residential health care facility and not for the purpose of attracting patients.

(i) Effective for fiscal years ending in 1976 and thereafter allowable costs per unit of service in a base year will not include any cost increases over the allowable costs in the prior year which are in excess of the inflation factor used by the Department in determining the reimbursement rate in effect during such base year, unless the cost increases in the base year resulted in a rate revision related to such year in accordance with §88.14.

(j) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(k) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the Commissioner, to be allocable to expenditures other than for public relations, advertising, or political contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the Commissioner.

88.18 Recoveries of expense. (a) Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold for use outside the residential health care facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to employees;

(5) employee cafeterias;

(6) meals provided to special nurses or patients' guests;

(7) operation of parking facilities for community convenience;

(8) lease of office and other space of concessionaires providing services not related to residential health care facility service;

(9) tuition and other payments for education service, room and board and other services not directly related to residential health care facility service.

88.19 Depreciation. (a) Reported depreciation based on approved historical cost of buildings, fixed equipment and improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method on plant and non-moveable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and non-moveable equipment.

(d) Residential health care facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Part. In lieu of depreciation and interest, on the loan financed portion of the facilities the State Commissioner of Health shall allow level debt service on the mortgage loan, together with such required fixed charges, sinking funds and reserves as may be determined by the Commissioner as necessary to assure repayment of the mortgage indebtedness.

88.20 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for voluntary and public residential health care facilities. For proprietary residential health care facilities, necessary interest is allowable except for those amounts related to land, building, fixed equipment and improvements thereto.

(b) To be considered as an allowable cost, interest shall be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have had to pay in the money market at the time the loan was made. Also, the interest shall be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower, except in instances where the prior approval of the Commissioner of Health has been obtained.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor restricted fund or funded depreciation is an allowable expense.

(d) Interest on capital debt in excess of 50 percent of the net depreciated value of buildings and fixed equipment for voluntary residential health care facilities shall not be considered an allowable cost, unless the State Commissioner of Health, as of July 1, 1971, has already finally approved the fiscal feasibility of a project, or thereafter shall have determined, after inviting written comments from interested parties that capital debt in excess of such amount is a matter of public interest and does not threaten the continued existence of the institution.

88.21 Capital cost reimbursement for proprietary residential health care facilities (effective January 1, 1976). (a) As used in this section the following terms shall have their respective meanings:

(1) Allowed facility cost. The term "allowed facility cost" shall mean the aggregate of the building portion and land portion determined by the Commissioner pursuant to this section.

(2) Approved book value. The term "approved book value" shall mean the total certified historical cost, net of accumulated depreciation or amortization thereof, of all assets constituting plant, non-moveable equipment and land actually used to provide necessary patient care to the extent said cost is approved by the Commissioner as reasonable, necessary and in the public interest

(3) Approved project cost. The term "approved project cost" shall mean the aggregate of costs actually incurred by the facility for the acquisition of land and the acquisition or construction

of plant and non-moveable equipment used to provide necessary patient care to the extent said costs are approved by the Commissioner as reasonable, necessary and in the public interest.

(4) Capital cost. The term "capital cost" in this section shall be related solely to the approved cost for land, building, fixed equipment and improvements thereto.

(5) Commissioner. The term "Commissioner" shall mean the State Commissioner of Health.

(6) Department. The term "Department" shall mean the State Department of Health.

(7) Facility. The term "facility" shall include every "residential health care facility" as that term is defined in Article 28 of the Public Health Law or in regulations of the Department, organized and operated on a for-profit basis.

(8) Improvement. The term "improvement" shall mean any addition to, replacement of or improvement of a capital item of plant or non-moveable equipment approved by the Commissioner as reasonable, necessary and in the public interest.

(9) Improvement cost. The term "improvement cost" shall mean the actual expenditure or portion thereof attributable to an improvement approved by the Commissioner as reasonable, necessary and in the public interest.

(10) Improvement period. The term "improvement period" shall mean the period of years represented by the greater of

(i) the remaining useful facility life as of the initial improvement year; or

(ii) the useful improvement life.

(11) Initial facility year. The term "initial facility year" shall mean the calendar year in which a facility commenced operations as determined by the Commissioner.

(12) Initial improvement year. The term "initial improvement year" shall mean the calendar year in which an improvement is first used by a facility in the provision of necessary patient care as determined by the Commissioner.

(13) Rate of return. The term "rate of return" shall mean the annual rate of return on net equity capital invested and used in the provision of patient care, as said rate is determined by the United States Department of Health, Education and Welfare as an element of reasonable cost for purposes of payments to or reimbursement of proprietary providers under Title XVIII of the federal Social Security Act.

(14) Useful facility life. The term "useful facility life" shall mean a period of forty years measured from the intial facility year.

(b) Subject to subdivision (c) of this section, the reimbursement rate of every proprietary residential health care facility certified by the Commissioner pursuant to Article 28 of the Public Health Law shall include a capital cost component determined in accordance with subdivision (d) or subdivision (e) of this section.

(c) The provisions of subdivision (b) of this section shall not apply to any facility which, as of the effective date of this section or therafter, is within the provisions of subdivision (g) or subdivision (h) of this section.

(d) (1) Except as provided by subdivision (c) of this section and subject to the provisions of paragraph (1) and paragraph (4) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the useful facility life, a payment factor representing an amount sufficient to pay, over the useful facility life, the Building Portion of allowed facility cost together with an annual rate of return thereon, as determined by the Commissioner in the initial facility year, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed Building Portion; and

(ii) for each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement together with an annual rate of return thereon, as determined by

the Commissioner in the initial improvement year, in equal constant annual payments as if each of such rate of return on the then unreimbursed amount of improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the then unreimbursed amount of improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient to pay an annual rate of return, determined by the Commissioner in the initial facility year, on the Land Portion of allowed facility cost.

(2) The payment factors provided by paragraph (1) of this subdivision shall be adjusted prospectively by the Commissioner at ten year intervals measured from the initial facility year or initial improvement year. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the adjustment and utilizing such average rate of return to recompute.

(i) the payment factor to be applied pursuant to paragraph (1)(i) of this section to the then remaining unreimbursed Building Portion of allowed facility cost over the then remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this section.

(3) For purposes of this section the Building Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to construction or acquisition of plant and nonmoveable equipment, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(4) For purposes of this section the Land Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to the acquisition of land, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(5) The Commissioner may, in his discretion, determine maximum per bed approved project costs related to the efficient production of services by a facility. For purposes of this section the

facility cost of any facility shall not exceed an amount equal to the applicable maximum per bed approved project cost times the number of beds specified in the operating certificate issued to the facility by the Commissioner pursuant to Article 28 of the Public Health Law. The Commissioner shall reduce the Building Portion or Land Portion of any facility whose approved project cost exceeds the maximum determined in accordance with this subsection by the amount which the Commissioner finds attributable to such portion.

(e) (1) Except as provided in Subdivision (c) of this section and subject to the provisions of paragraphs (3), (4), (7), (8) and (9) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurred prior to the calendar year in which this section becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the then remaining useful facility life, a payment factor representing an amount sufficient to pay, over the remaining useful facility life, the remaining unreimbursed Building Portion of allowed facility cost, together with an annual rate of return thereon determined pursuant to paragraph (2) of this section, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed amount of the Building Portion and the remainder of each such annual payment were to be applied in reduction of the Building Portion; and

(ii) For each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement, together with an annual rate of return thereon determined pursuant to paragraph (2) of this section, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the improvement cost of such improvement: and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient either (a) to pay an annual rate of return determined pursuant to paragraph (2) of this section on the Land Portion of allowed facility cost or (b) to reimburse the facility for the total payments or approved portion thereof made by the facility for the use of land rented pursuant to a lease which meets the specifications of subparagraphs (i), (ii) and (iii) of subdivision (h) (1) of this subpart.

(2) The rate of return used to determine the payment factors pursuant to paragraph (1) of this section shall

(i) for facilities whose initial facility year was at least five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the five years preceding the year in which this subpart becomes effective or

(ii) for facilities whose initial facility year was less than five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the years in which the facility was established by the Public Health Council and operated pursuant to an operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law.

(3) The payment factors provided by paragraph (1) of this section shall be adjusted prospectively by the Commissioner at ten year intervals measured from the year in which this subpart becomes effective. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the

adjustment and utilizing such average rate of return to recompute

(i) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed Building Portion of allowed facility cost over the remaining useful facility life and

(ii) for facilities whose initial facility year was less than five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the years in which the facility was established by the Public Health Council and operated pursuant to an operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law.

(3) The payment factors provided by paragraph (1) of this section shall be adjusted prospectively by the Commissioner at ten year intervals measured from the year in which this subpart becomes effective. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the adjustment and utilizing such average rate of return to recompute.

(i) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed Building Portion of allowed facility cost over the remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this section.

(4) Notwithstanding the provisions of paragraph (1) of this section, the capital cost component for facilities whose initial facility year was more than 20 years prior to the year in which this subpart becomes effective and which are found by the Commissioner to comply in all respects with the provisions of the State Hospital Code shall

(i) for the remaining useful facility life be not less than an amount equal to $200 multiplied by the number of beds specified in the operating certificate issued to such facility by the Commissioner pursuant to Article 28 of the Public Health Law; and

(ii) for each year beyond the remaining useful facility life consist of the payment factor

applicable to such facility pursuant to paragraph (1) (iii) of this subdivision.

(5) Except as provided in subsection (i) of this paragraph, for purposes of this section the Building Portion of allowed facility co shall consist of the portion of the approved book value of a facility attributed by the Commissioner to plant and non-moveable equipment, as adjusted by the Commissioner pursuant to paragraph (7) and paragraph (8) of this subdivision.

(6) Except as provided in paragraph (9) of this subdivision, for purposes of this section the Land Portion of allowed facility cost shall consist of the portion of the approved book value of a facility attributed by the Commissioner to land, as adjusted pursuant to paragraph (7) and paragraph (8) of this section.

(7) The Commissioner shall reduce the approved book value of any facility so as to disregard prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(8) The Commissioner may, in his discretion, reduce the approved book value of the facility to take into account such factors as the age, size, location and condition of the facility.

(9) In lieu of determing allowed facility cost pursuant to paragraph (5) and Paragraph (6) of this subdivision, the Commissioner shall, based on approved project cost or approved book values of facilities of comparable age, size, location and condition, assign

an allowed facility cost, and allocate the same between the Building Portion and Land Portion thereof, to

(i) every leased facility which operates under a lease which the Commissioner finds to be other than bona fide or the terms of which are found to be other than fair and reasonable; and

(ii) every facility for which records on asset book values are not available or not verifiable to the satisfaction of the Commissioner; and

(iii) every facility which, after the effective date of this subpart, ceases to be eligible for reimbursement pursuant to subdivision (h) of this subpart; and

(iv) every facility whose construction was completed prior to the calendar year in which this subpart becomes effective and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective.

provided that this section shall not apply to any such facility which is able to provide the Commissioner with information which the Commission finds sufficient to determine its approved book value.

(f) Subject to the provisions of subdivision (g) of this subpart, the capital cost component of any facility that is sold, transferred or the subject of any other transaction after March 10, 1975 shall be determined in accordance with the provisions of this section as if such sale, transfer or other transaction had not occurred.

(g) (1) Notwithstanding the provisions of subdivision (b) and subdivision (f) of this subpart, the capital cost component of any facility shall, upon the sale or transfer of such facility to a voluntary sponsor or the conversion of such facility to a voluntary facility, be determined pursuant to sections 88.19 and 88.20 of this part and paragraph (2) of this section.

(2) The approved book value of a facility within paragraph (1) of this section, determined for purposes of sections 88.19 and 88.20 shall be determined in accordance with the provisions of this section as though such sale, transferor conversion had not occurred.

(h) (1) The provisions of subdivision of this section shall not apply to any facility which, as of the effective date of this subpart, is located in and operated from leased space pursuant to a lease

(i) which was entered into and approved for reimbursement prior to March 10, 1975; and

(ii) which the Commissioner finds to be bona fide, valid and non-cancellable; and

(iii) the terms of which the Commissioner finds to be fair and reasonable; and

(iv) the payments or portion thereof made pursuant to which are found by the Commissioner to be the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of this section shall consist of a payment factor sufficient to reimburse the facility for the total payments required under the lease thereof to the extent approved by the Commissioner pursuant to paragraph (1) of this subdivision.

√ 88.22 Moveable Equipment. Necessary and reasonable expenses related to moveable equipment (depreciation computed on a straight line method or accelerated under a double declining balance on sum-of-the years digits method, interest on indebtedness, lease etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

88.23 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

88.24 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.

88.25 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

88.26 Costs of related organizations. (a) Costs applicable to rvices, facilities and supplies furnished to a residential health

care facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate shall include both the costs of the related organization in providing the services, facilities and supplies (and a return on the equity capital of the related organization).

88.27 Termination of service. The Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 88.7 of this Part.

88.28 Return on investment. In computing the allowable costs of a proprietary residential health care facility, there will be included a reasonable return on net equity capital, excluding capital invested in land, plant, fixed equipment and improvements thereto, invested for necessary and proper operation for patient care activities. The percentage to be used in computing this allowance will be a rate determined annually by the commissioner as reasonably related to the then current money market.

88.29 These regulations shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 1976.

EXHIBIT H

SUBPART 86-2

REPORTING AND RATE CERTIFICATION FOR RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, § 2808)

Sec.

86-2.1 Definition
86-2.2 Financial and statistical data required
86-2.3 Uniform system of accounting and reporting
86-2.4 Generally accepted accounting principles
86-2.5 Accountant's certification
86-2.6 Certification by operator or officer
86-2.7 Audits
86-2.8 Patient days
86-2.9 Effective period of reimbursement rates
86-2.10 Computation of basic rate
86-2.11 Ceilings on allowable costs for reimbursement purposes
86-2.12 Adjustments to basic computed rate
86-2.13 Final rates
86-2.14 Revisions in certified rates
86-2.15 Rates for residental health care facilities without adequate cost experience
86-2.16 Less expensive alternatives
86-2.17 Allowable costs
86-2.18 Recoveries of expense
86-2.19 Depreciation
86-2.20 Interest
86-2.21 Capital cost reimbursement for proprietary residential health care facilities (effective January 1, 1976)
86-2.22 Moveable equipment
86-2.23 Research
86-2.24 Educational activities
86-2.25 Compensation of operators and relatives of operators
86-2.26 Costs of related organizations
86-2.27 Termination of service
86-2.28 Return on investment
86-2.29 Effective date

Section 86-2.1 Definition. As used in this Subpart, the term "residential health care facility" shall be deemed to include all facilities or organizations covered by the term "nursing home or health related facility" as defined in Article 28 of the Public Health Law, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and where

required, has been established by the Public Health Council.

86-2.2 Financial and statistical data required. (a) Each residential health care facility shall complete and file with the New York State Department of Health and/or its agent, annual financial and statistical report forms supplied by the department and/or its agent. Residential health care facilities certified for title XVIII of the federal Social Security Act (medicare) shall use the same fiscal year for title XIX/of the federal Social Security Act (medicaid) as is used for title XVIII. All residential health care facilities must report their operations from January 1, 1977 forward on a calendar year basis.

(b) Financial and statistical reports required by this/Sub Part shall be submitted to the department and/or its agent no later than 120 days following the close of the fiscal period. Extensions of time for filing reports may be granted upon application received at least 15 days prior to the due date of the report and only in those circumstances where the residential health care facility established, by documentary evidence, that the report cannot be filed by the due date for reasons beyond the control of the facility.

(c) In the event a residential health care facility fails to file the required financial and statistical report on or before the due dates, or as the same may be extended pursuant to paragraph (b) of this section, the State Commissioner of Health shall reduce the current rate by two percent for a period beginning on the first day

of the calendar month following the due date of the required report and continuing until the last day of the calendar month in which said required report is filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the Department a correction of such information or data which meets the same certification requirements as the document being corrected.

(e) A cost report must be filed in accordance with this section by each new facility for the first six month period during which the facility has had an over-all average utilization of at least 90 percent of bed capacity. This report must be filed and properly certified within 60 days following the end of the six month period covered by the report.

86-2.3 Uniform system of accounting and reporting. Residential health care facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health. Records shall be maintained by residential health care facilities in accordance with the appropriate section of the/ Medical Facilities, Minimum Standards, being Subchapter A of Chapter V of thi Ti ~~State-Hospital-Code~~. Rate schedules shall not be certified by the Commissioner of Health unless

residential health care facilities are in full compliance with all reporting requirements.

86-2.4 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorize specific variation in such principles.

86-2.5 Accountant's certification. The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish. The requirements of this Section shall not apply to residential health care facilities operated by units of government of the State of New York.

86-2.6 Certification by operator or officer. The financial and statistical reports shall be certified by the operator or an officer of the medical facility.

86-2.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted of the records of residential health care facilities, in a manner to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (medicare-medicaid and other organizations and agencies having audit responsibilities) to

satisfy the department's auditing needs.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department. This limitation shall not apply to situations in which fraud may be involved.

(d) Residential health care facilities shall be given 30 days after the mailing of notification of audit findings to appeal such findings, by submitting data intended to justify the facility's position in the areas of disagreement. Failure by the residential health care facility to reply to such findings within the 30 day period, or to receive from the department an extension of time for reply shall be considered as acceptance of the findings.

(e) Rate revisions resulting from audit findings may be made retroactively to the period or periods during which the rates based on the periods audited were established.

(f) All overpayments resulting from rate revisions shall bear interest at the rate of seven percent per annum from the date of such overpayments and be subject to such penalties as the Commissioner of Health may impose for the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions.

86-2.8. Patient days. (a) A "patient day" is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

86-2.9 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies pursuant to this/Subpart shall be for the rate period beginning January 1, 1976 and ending March 31, 1977.

86-2.10 Computation of basic rate. Basic rates shall be computed on the basis of allowable fiscal and statistical data submitted by the residential health care facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs shall be made.

I T A L I C S

86-2.11 Ceilings on allowable costs for reimbursement purposes.

(a) For the purpose of establishing allowable cost ceilings for determining reimbursement rates effective January 1, 1976 for governmental payments, skilled nursing facilities and health related facilities will be grouped separately with respect to size as indicated in (1) below and with respect to the service ratings received for those functions indicated in (i) through (v) in (2) below and by size only with respect to (vi) in (2) below:

(1) Size of facilities

(i) 50 beds and under
(ii) 51 to 99 beds
(iii) 100 to 199 beds
(iv) 200 to 299 beds
(v) over 300 beds

(2) Functions

(i) Nursing
(ii) Food-Nutrition
(iii) Leisure Time Activities
(iv) Cleanliness and Safety
(v) Social Work
(vi) Administration

(b) Allowable costs for reimbursement for any function for which a facility receives a "Good - State" rating may not exceed the 60th percentile of the perdiem range of costs as reported for the base year by all facilities receiving a "Good - State" service rating for that rated function within the size groups as indicated in (a) (1) above.

(c) Allowable costs for reimbursement for any rated function for which a facility receives a "Good - Federal" service rating

I T A L I C S

may not exceed the 35th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(d) Allowable costs for reimbursement for any rated function for which a facility receives a "Needs Improvement" rating may not exceed the 25th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(e) Allowable costs for reimbursement for any rated function for which a facility receives an "Unacceptable" rating may not exceed the 10th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(f) Ceilings will not be imposed on costs for any rated function for which a facility receives a "Very Good" service rating.

(g) Allowable per diem costs for administration may not exceed the 50th percentile of the range of per diem costs reported for the base year for all facilities within the size groups indicated in (a) (1) above.

(h) In establishing the ranges of per diem costs, by function, facilities will be grouped without regard to sponsor or geographic area. An economic leveling factor developed on the basis of area salaries will be used to make the costs comparable.

ITALICS

(i) Any amount to be eliminated in accordance with this section in determining reimbursement rates will be equal to the excess of the total per diem costs computed from the total costs reported in the base year for the functions in (a) (2) above over the total of the functional ceilings established for the service ratings and administration of the facility.

86-2.12 Adjustments to basic computed rate.

(a) To the allowable basic rate, computed in accordance with ceiling limitations, and prior to the addition of capital costs, realty leases, return on net equity capital, and leases, depreciation and interest related to equipment there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a residential health care facility's cost shall be weighted based on a sampling of data by the following categories:

(i) Salaries and employee health and welfare expense to be computed based on a total of sub-weights.
(ii) Nonpayroll administrative and general expense.
(iii) Nonpayroll household and maintenance expense.
(iv) Nonpayroll dietary expense.
(v) Nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United

States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(b) During the rate period, the cost indicators used in determining the projection factors in establishing the current certified rates may be compared with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health, as of mid-point in the rate period. Based upon such review the Commissioner may, in his discretion either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

86-2.13 Final rates. Rate adjustments may be made to correct errors in the determination of rates.

~~However~~ Errors resulting from submission of information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the commissioner's rate computation sheet. Errors resulting from the rate computation process may be corrected if brought to the attention of the commissioner within four months of receipt of the commissioner's rate computation sheet.

86-2.14 Revisions in certified rates. (a) The State Commissioner of Health may consider only those applications for prospective revisions of certified rates which are based on

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a residential health care facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 88.13;

(3) significant increases in the over-all operating costs of a residential health care facility resulting from the implementation of additional programs, staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the facility by the Commissioner;

(5) requests for waivers of any provisions of ~~Part 88~~ this Subpart for which waivers may be granted by the Commissioner as prescribed in specific sections; and

(6) changes in the method of providing services which result in a lower over-all cost for the services provided;

(7) requests for relief from the ceiling provisions of this

part. For such relief, a residential health care facility must demonstrate that its range of approved services, patient mix, lengths of appropriate stays or other pertinent factors are direct causes for all or part of the costs in excess of the ceilings. Such relief shall not result in a rate which exceeds that based on maximum reimbursable State standards, unless a waiver of such standards is granted by the Commissioner. If relief is granted, the resulting revised rates shall become effective as of the first day of the rate period.

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(d) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the Commissioner shall notify the requesting party of his determination.

(e) In reviewing appeals for revisions to certified rates the Commissioner may refuse to accept or consider an appeal from a residential health care facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital and Planning Council in one of its facilities;

(3) where it has been determined by the Commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

In such instances subdivision (c) of this section shall not be effective until the date the appeal is accepted by the Commissioner.

(f) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(g) Any residential health care facility eligible for title XVIII of the federal Social Security Act (medicare) certification providing services to patients insured under title XVIII of the federal Social Security Act which is not, or ceases to be, a title XVIII provider of

I T A L I C S

care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

86-2.15 Rates for residential health care facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

(a) The usual and customary rates, for comparable services, in the geographic area.

(b) Satisfactory cost projections.

(c) Allowable actual expenditures.

(d) An anticipated utilization of no less than the average for the geographic area or the minimums established in this Subpart, whichever is greater.

86-2.16 Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served effective alternatives or substitutes for the whole or any part of such service.

ITALICS

to patient care or treatment which principally afford diversion, entertainment or amusement to owners, operators or employees of residential health care facilities.

(g) Allowable costs shall not include any interest charged related to rate determination or penalty imposed by governmental agencies or courts, and the costs of policies obtained solely to insure against the imposition of such a penalty.

(h) Allowable costs shall not include the direct or indirect costs of advertising, public relations, or promotion except in those instances where the advertising is specifically related to the operation of the residential health care facility and not for the purpose of attracting patients.

(i) Effective for fiscal years ending in 1976 and thereafter allowable costs per unit of service in a base year ~~will~~ shall not include any cost increases over the allowable costs in the prior year which are in excess of the inflation factor used by the New York State Department of Health in determining the reimbursement rate in effect during such base year, unless the cost increases in the base year resulted in a rate revision related to such year in accordance with section 86-2.17.

(j) Allowable costs shall not include costs of contributions or other payments to political parties, candidates or organizations.

(k) Allowable costs shall include only that portion of the dues paid to any professional association which has been demonstrated, to the satisfaction of the Commissioner, to be allocable to expenditures other than for public relations, advertising, or political

86-2.17 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs must be properly chargeable to necessary patient care. Except as otherwise provided in this Subpart, or in accordance with specific determination by the Commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under the title XVIII of the Federal Social Security Act (medicare) program.

(b) Allowable cost shall include a monetary value assigned to services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII of the Federal Social Security Act (medicare) costs or in excess of customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of expenses reported by individual residential health care facilities which are determined by the Commissioner not to be reasonably related to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the Commissioner, as to allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(f) Allowable costs shall not include costs not properly related

ITALICS

contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the Commissioner.

86-2.18 Recoveries of expense. (a) Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold for use outside the residential health care facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to employees;

(5) employee cafeterias;

(6) meals provided to special nurses or patients' guests;

(7) operation of parking facilities for community convenience;

(8) lease of office and other space of concessionaires providing services not related to residential health care facility service;

(i) the remaining useful facility life as of the initial improvement year; or

(ii) the useful improvement life.

(11) Initial facility year. The term "initial facility year" shall mean the calendar year in which a facility commenced operations as determined by the Commissioner.

(12) Initial improvement year. The term "initial improvement year" shall mean the calendar year in which an improvement is first used by a facility in the provision of necessary patient care as determined by the Commissioner.

(13) Rate of return. The term "rate of return" shall mean the annual rate of return on net equity capital invested and used in the provision of patient care, as said rate is determined by the United States Department of Health, Education and Welfare as an element of reasonable cost for purposes of payments to or reimbursement of proprietary providers under Title XVIII of the federal Social Security Act.

(14) Useful facility life. The term "useful facility life" shall mean a period of forty years measured from the intial facility year.

(b) Subject to subdivision (c) of this section, the reimbursement rate of every proprietary residential health care facility certified by the Commissioner pursuant to Article 28 of the Public Health Law shall include a capital cost component determined in accordance with subdivision (d) or subdivision (e) of this section.

(c) The provisions of subdivision (b) of this section shall not apply to any facility which, as of the effective date of this section or therafter, is within the provisions of subdivision (g) or subdivision (h) of this section.

(d) (1) Except as provided by subdivision (c) of this section and subject to the provisions of paragraph (1) and paragraph (4) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the useful facility life, a payment factor representing an amount sufficient to pay, over the useful facility life, the Building Portion of allowed facility cost together with an annual rate of return thereon, as determined by the Commissioner in the initial facility year, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed Building Portion; and

(ii) for each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement together with an annual rate of return thereon, as determined by

the Commissioner in the initial improvement year, in equal constant annual payments as if each of such rate of return on the then unreimbursed amount of improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the then unreimbursed amount of improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient to pay an annual rate of return, determined by the Commissioner in the initial facility year, on the Land Portion of allowed facility cost.

(2) The payment factors provided by paragraph (1) of this subdivision shall be adjusted prospectively by the Commissioner at ten year intervals measured from the initial facility year or initial improvement year. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the adjustment and utilizing such average rate of return to recompute.

(i) the payment factor to be applied pursuant to paragraph (1)(i) of this section to the then

ITALICS

remaining unreimbursed Building Portion of allowed facility cost over the then remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this section.

(3) For purposes of this section the Building Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to construction or acquisition of plant and nonmoveable equipment, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(4) For purposes of this section the Land Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to the acquisition of land, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(5) The Commissioner may, in his discretion, determine maximum per bed approved project costs related to the efficient production of services by a facility. For purposes of this section the

facility cost of any facility shall not exceed an amount equal to the applicable maximum per bed approved project cost times the number of beds specified in the operating certificate issued to the facility by the Commissioner pursuant to Article 28 of the Public Health Law. The Commissioner shall reduce the Building Portion or Land Portion of any facility whose approved project cost exceeds the maximum determined in accordance with this subsection by the amount which the Commissioner finds attributable to such portion.

(e) (1) Except as provided in Subdivision (c) of this section and subject to the provisions of paragraphs (3), (4), (7), (8) and (9) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurred prior to the calendar year in which this section becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the then remaining useful facility life, a payment factor representing an amount sufficient to pay, over the remaining useful facility life, the remaining unreimbursed Building Portion of allowed facility cost, together with an annual rate of return thereon determined pursuant to paragraph (2) of this section, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed amount of the Building Portion and

ITALICS

the remainder of each such annual payment were to be applied in reduction of the Building Portion; and

(ii) For each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement, together with an annual rate of return thereon determined pursuant to paragraph (2) of this section, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient either (a) to pay an annual rate of return determined pursuant to paragraph (2) of this section on the Land Portion of allowed facility cost or (b) to reimburse the facility for the total payments or approved portion thereof made by the facility for the

ITALICS

use of land rented pursuant to a lease which meets the specifications of subparagraphs (i), (ii) and (iii) of subdivision (h) (1) of this subpart.

(2) The rate of return used to determine the payment factors pursuant to paragraph (1) of this section shall

(i) for facilities whose initial facility year was at least five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the five years preceding the year in which this subpart becomes effective or

(ii) for facilities whose initial facility year was less than five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the years in which the facility was established by the Public Health Council and operated pursuant to an operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law.

(3) The payment factors provided by paragraph (1) of this section shall be adjusted prospectively by the Commissioner at ten year intervals measured from the year in which this subpart becomes effective. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the

ITALICS

adjustment and utilizing such average rate of return to recompute

(i) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed Building Portion of allowed facility cost over the remaining useful facility life and

(ii) for facilities whose initial facility year was less than five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the years in which the facility was established by the Public Health Council and operated pursuant to an operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law.

(3) The payment factors provided by paragraph (1) of this section shall be adjusted prospectively by the Commissioner at ten year intervals measured from the year in which this subpart becomes effective. Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the adjustment and utilizing such average rate of return to recompute.

(i) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then

ITALICS

remaining unreimbursed Building Portion of allowed facility cost over the remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this section to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this section.

(4) Notwithstanding the provisions of paragraph (1) of this section, the capital cost component for facilities whose initial facility year was more than 20 years prior to the year in which this subpart becomes effective and which are found by the Commissioner to comply in all respects with the provisions of the State Hospital Code shall

(i) for the remaining useful facility life be not less than an amount equal to $200 multiplied by the number of beds specified in the operating certificate issued to such facility by the Commissioner pursuant to Article 28 of the Public Health Law; and

(ii) for each year beyond the remaining useful facility life consist of the payment factor

applicable to such facility pursuant to paragraph (1) (iii) of this subdivision.

(5) Except as provided in subsection (i) of this paragraph, for purposes of this section the Building Portion of allowed facility cost shall consist of the portion of the approved book value of a facility attributed by the Commissioner to plant and non-moveable equipment, as adjusted by the Commissioner pursuant to paragraph (7) and paragraph (8) of this subdivision.

(6) Except as provided in paragraph (9) of this subdivision, for purposes of this section the Land Portion of allowed facility cost shall consist of the portion of the approved book value of a facility attributed by the Commissioner to land, as adjusted pursuant [illegible] paragraph (7) and paragraph (8) of this section.

(7) The Commissioner shall reduce the approved book value of any facility so as to disregard prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(8) The Commissioner may, in his discretion, reduce the approved book value of the facility to take into account such factors as the age, size, location and condition of the facility.

(9) In lieu of determing allowed facility cost pursuant to paragraph (5) and Paragraph (6) of this subdivision, the Commissioner shall, based on approved project cost or approved book values of facilities of comparable age, size, location and condition, assign

an allowed facility cost, and allocate the same between the Building Portion and Land Portion thereof, to

(i) every leased facility which operates under a lease which the Commissioner finds to be other than bona fide or the terms of which are found to be other than fair and reasonable; and

(ii) every facility for which records on asset book values are not available or not verifiable to the satisfaction of the Commissioner; and

(iii) every facility which, after the effective date of this subpart, ceases to be eligible for reimbursement pursuant to subdivision (h) of this subpart; and

(iv) every facility whose construction was completed prior to the calendar year in which this subpart becomes effective and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective.

provided that this section shall not apply to any such facility which is able to provide the Commissioner with information which the Commission finds sufficient to determine its approved book value.

(f) Subject to the provisions of subdivision (g) of this subpart, the capital cost component of any facility that is sold, transferred or the subject of any other transaction after March 10, 1975 shall be determined in accordance with the provisions of this section as if such sale, transfer or other transaction had not occurred.

(g) (1) Notwithstanding the provisions of subdivision (b) and subdivision (f) of this subpart, the capital cost component of any facility shall, upon the sale or transfer of such facility to a voluntary sponsor or the conversion of such facility to a voluntary facility, be determined pursuant to sections 86-2.19 and 86-2.20 of this Sub/part and paragraph (2) of this section.

(2) The approved book value of a facility within paragraph (1) of this section, determined for purposes of sections 86-2.19 and 86-2.20 of this Subpart shall be determined in accordance with the provisions of this section as though such sale, transferor conversion had not occurred.

(h) (1) The provisions of subdivision of this section shall not apply to any facility which, as of the effective date of this subpart, is located in and operated from leased space pursuant to a lease

(i) which was entered into and approved for reimbursement prior to March 10, 1975; and

(ii) which the Commissioner finds to be bona fide, valid and non-cancellable; and

(iii) the terms of which the Commissioner finds to be fair and reasonable; and

(iv) the payments or portion thereof made pursuant to which are found by the Commissioner to be the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of this section shall consist of a payment factor sufficient to reimburse the facility for the total payments required under the lease thereof to the extent approved by the Commissioner pursuant to paragraph (1) of this subdivision.

86-2.22 Moveable Equipment. Necessary and reasonable expenses related to moveable equipment (depreciation computed on a straight line method or accelerated under a double declining balance on sum-of-the years digits method, interest on indebtedness, lease etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

86-2.23 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understandings, are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

86-2.24 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.

86-2.25 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question.

86-2.26 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to a residential health

care facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate shall include both the costs of the related organization in providing the services, facilities and supplies (and a return on the equity capital of the related organization).

86-2.27 Termination of service. The Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpayments by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-2.7 of this Sub/part.

86-2.28 Return on investment. In computing the allowable costs of a proprietary residential health care facility, there will be included a reasonable return on net equity capital, excluding capital invested in land, plant, fixed equipment and improvements thereto, invested for necessary and proper operation for patient care activities. The percentage to be used in computing this allowance will be a rate determined annually by the commissioner as reasonably related to the then current money market.

86-2.29/ Effective date. These regulations shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 1976.

EXHIBIT I

NEW YORK STATE DEPARTMENT OF HEALTH MONOGRAPH NO. 10

183

NURSING HOMES AND THEIR PATIENTS

NEW YORK STATE
1972

NEW YORK STATE DEPARTMENT OF HEALTH
ALBANY, N.Y.
OCTOBER, 1975

184

Summary and Highlights

1. Despite the phasing out of a number of proprietary homes and an increase in the number of voluntary facilities, the for-profit sector has substantially increased its share of total beds during the five-year period under study, from 58 percent to 65 percent as a result of the construction of new large size proprietary facilities.
2. The share of patients covered by the Medicaid program increased sharply to 80 percent in 1972, primarily due to administrative tightening of the Medicare program which sharply decreased its share of financial participation down to 1.3 percent.
3. More patients were fully ambulatory in proprietary facilities than in voluntary facilities, and the length of stay was shorter in proprietary facilities.
4. Medicare patients had the shortest length of stay due to the limited coverage of the program, the requirement for prior hospitalization and the administrative tightening noted above. Medicaid patients had the longest length of stay.
5. The costs per day almost doubled during the 1967–72 period, largely due to increases in wage and fringe benefits and the construction of new, more costly facilities, many of which replaced older, substandard and less expensive facilities.
6. Approximately three-quarters of patients in nursing homes are female. Females tend to be older than males with a concentration over the age of 75. Thus as senescence takes its toll, the probability of a female over the age of 75 being admitted to a nursing home tends to increase.
7. Percentagewise, many more patients are discharged to hospitals from proprietary facilities than from voluntaries.
8. Based on estimates derived from the statistics noted in this report and population statistics for those 65 and over, approximately five percent of persons age 65 and over were at one time residing in a nursing home or health-related facility. The percentage was below five percent for those 65 to 74, but increased significantly for the 75 to 84 group, and 85 and older as the number of persons in nursing homes increased with advanced age while the population at risk declined.

Nursing Homes in New York State
1972

This report is another in a series prepared by the Health Department relating to facilities providing nursing care in New York State and the patients whom they serve. The data in the report cover the year 1972 and five-year trends are noted, with 1967 the last year for which data have been published. The information presented in this report was derived from the annual reports (HE–2) submitted by nursing homes. These data reflect a certification by an independent licensed or certified public accountant, but do not reflect adjustments resulting from a State audit.

At the close of 1972, there were 514 skilled nursing homes filing HE–2 reports in New York State compared with 598 in 1967, the decrease resulting from the closing of substandard facilities. (There were a number of nursing homes not participating in the Medicaid program and not filing HE–2 reports, so that the actual number of skilled nursing homes in 1972, excluding hospital-based facilities, was 547.) Of the 514 homes, 363 or 71 percent were proprietary, 114 or 22 percent were voluntary, and 37 or 7 percent were public.

Proprietary nursing homes accounted for 65 percent of all the beds in 1972 compared with 58 percent in 1967. Nonprofit nursing home beds accounted for 22 percent, and public, 12 percent of the total. There were significant variations by region. For instance, in New York City proprietary beds accounted for 70 percent of the total whereas in Upstate New York the corresponding figure was 56 percent.

In New York City almost two-thirds of the beds were in homes of over 200 bed size. This is in striking contrast to Upstate New York where over 80 percent of the beds were in facilities of under 200 beds (Table 1).

Proprietary Nursing Homes

The 363 proprietary nursing homes representing 71 percent of the beds were distributed as follows geographically: New York City, 102; Long Island, 47; Northern Metropolitan, 54; and Upstate New York, 160. Almost half of the beds were located in New York City, 13 percent were on Long Island, 11 percent were in the Northern Metropolitan region, and 30 percent were in Upstate New York. Over 86 percent of the proprietary nursing homes were under 200 bed size. The occupancy rate in 1972 was at a 98.1 percent level, four percentage points higher than five years ago. In every county in the State the percent occupancy exceeded 94 percent.

On a Statewide basis, 78.5 percent of the patients in proprietary nursing homes were covered by the Medicaid program. In New York City the figure was considerably higher at 91 percent. By contrast, in 1967 59.1 percent of patients on a Statewide basis were covered by Medicaid and 71.0 percent were Medicaid patients in New York City. The striking increase in the Medicaid program's assuming a greater share of the financial burden has been due in no small part to the decline of Medicare participation, from 11.7 Statewide in 1967 down to 1.3 percent in 1972.

Self-pay patients accounted for 20.2 percent of all patients in proprietary homes in 1972. Many of the self-pay patients were going through the process of "spend-down", i.e., spending their financial resources until they were at the Medicaid eligibility level at which point Medicaid would assume the costs of their care.

Almost 30 percent of the patients in proprietary homes were nonambulant, with great variations around the State. The corresponding figure for New York City was 26.4 percent with some upstate counties registering figures as high as 45 to 60 percent. A possible explanation is that patients in upstate facilities may be institutionalized due to more severe medical problems while in New York City social factors may be a contributory cause, i.e., family disruption, housing problems, etc.

There were 33,889 patients in proprietary homes at the close of 1972 compared with 24,615 five years earlier. The increasing number of institutionalized patients plus the greater assumption of financial obligations by the Medicaid program have contributed to the increasing costs of nursing home care in the State's Title XIX program. Moreover the costs per day have increased during this five-year span from $15.18 to $28.97 for a 91 percent increase, reflecting for the most part increases in wage and fringe benefits, the construction of new, more costly facilities, and Hospital Code changes designed to improve the quality of care. The Consumer Price Index during that period rose 25 percent.

More than two-thirds of the male patients were over the age of 75, and over one-quarter of all males were over the age of 85. However, male patients accounted for only 26 percent of all patients. The female group tends to be older than the males, with 78 percent over the age of 75 and one-third over the age of 85.

More than one-third of the patients in proprietary homes were fully ambulant.

Of the 27,672 patients discharged during 1972, 43 percent were sent to a hospital, over 30 percent died, over 16 percent returned to their own homes, 6 percent were transferred to another nursing home and a variety of other discharges accounted for 3.5 percent. New York City had the highest percentage of discharges to a hospital, 56.9 percent. This is in striking contrast with the nonprofit homes in New York City which account for only 14.1 percent of all discharges to a hospital.

Of the 30,361 admissions during the year in proprietary institutions, 71.2 percent were admitted from hospitals, almost 19 percent were admitted from their own homes, 7 percent were admitted from another nursing home and 3 percent from a miscellaneous category.

Almost half of the patients discharged during 1972 remained in the nursing home for less than three months. The median length of stay in the State was four months. Slightly over one-quarter of the patients discharged remained in the nursing facility from three months to a year; another 25 percent had stays from one to five years, and 3 percent stayed five years or more. Medicaid patients tended to have longer stays with a third of those discharged remaining one to five years. The median length of stay for Medicaid patients was 7.3 months.

Medicare patients were covered for 100 days in a skilled nursing facility after a three-day stay in a hospital. More than half of all Medicare patients remained less than one month. Another third remained from one to three months and only 9 percent from three to six months. The median length of stay of Medicare patients was approximately 27 days.

Assets per bed in proprietary nursing homes tended to increase by size ranging from $5,223 for the under-50 bed size to $10,462 for homes of 300 beds and over. The highest ratio of assets per bed was reported in Rochester in the 200–299 bed size, amounting to $31,525. Assets per bed upstate tended to be higher than in New York City.

Equity per bed was higher in the under 50-bed size since indebtedness is incurred with new large size facilities. In all areas of the State except New York City equity was over $1,000 per bed. The largest proprietary facilities, all in New York City and presumably all newer homes, had equity of $245 per bed.

Voluntary Nursing Homes

There were 114 voluntary nursing home facilities in New York State in 1972, or 65 more than the 49 in operation in 1967. Despite the increase in the number of voluntary homes, and decrease in the proprietaries, the private sector increased its share of the total beds available. Proprietary homes were three times the number of voluntary homes.

The number of beds in voluntary homes increased from 9,607 in the earlier period to 12,222 in 1972, a 27 percent increase. Of the total, 51 homes had fewer than 50 beds; 30 had from 50–99 beds; 18 were in the 100–199 bed size; 5 had 200–299 beds; and 10 had 300 beds or more. One-third of the beds were in the ten largest size homes. More than half of the voluntary nursing home beds were located in New York City.

The occupancy rate in voluntary facilities in the State was 96.7 with most counties reporting occupancy rates in the upper range of the 90's.

Of the total 9,959 residents, 77 percent were covered by the Medicaid program in 1972 compared with 49.2 percent in 1967. New York City had higher than average Medicaid coverage at 87 percent and 66 percent, respectively.

Approximately 24 percent of the patients in voluntary homes in New York City were nonambulant compared with 30 percent upstate. In 1967, 40 percent of the patients in New York City were nonambulant. The sharp drop in bedfast patients may represent either a change in the case mix, or a change in the method of classification.

Slightly more than one-quarter of the patients in voluntary nursing homes were fully ambulant compared with more than a third in proprietary institutions. Thus the proprietary homes tend to care for a relatively larger share of healthier patients.

Males in voluntary homes accounted for 22 percent of the residents at the end of 1972, down somewhat from the 29.2 percent in 1967. There is thus a growing disparity between the number of men and women in these facilities. Males 75 and over accounted for 76 percent of the total male population at the homes, and those over 85 accounted for 34 percent. Among the females, those 75 and over accounted for 85 percent, and those 85 and over, 43 percent.

Persons on Medicaid represented 77 percent; Medicare, 1.2 percent; self-pay, 9.0 percent; and other, 2.8 percent. In New York City, those on Medicaid accounted for 86.8 percent of the total while in Upstate New York corresponding figures ranged from 55 to 68 percent. In the voluntary institutions, death was the major reason for discharge from the facility. Approximately 18 percent of the discharges were to a hospital and another 18 percent to the patient's own home. There may be fewer discharges to a hospital from the voluntary as opposed to the proprietary institutions because some voluntary homes are staffed and equipped to care for acutely ill patients.

Almost half of all patients were admitted from a hospital, but a considerably lower percentage than in the proprietary facilities. The second largest source of admission was the ambiguous term "other".

Patients in nonprofit nursing homes experienced a median length of stay of 4.5 months, somewhat higher than the four months for proprietary facilities. The stay for Medicaid patients was more than twice that of the overall average, 10.9, with Medicare patients experiencing the shortest length of stay, approximately 27 days.

By region, the longest length of stay was experienced in the Long Island area, averaging 14.5 months for all patients and almost 2–1/2 years for Medicaid patients. It should be noted that there are only three nonprofit homes on Long Island.

One-quarter of the patients in voluntary facilities remained for over two years compared with only 15 percent in proprietary facilities. The percentage staying less than one month was also far greater in the voluntary nursing homes compared with proprietary, 31 percent compared with 24 percent, respectively. These patients may reflect post-hospital convalescents and those who may die shortly after admission.

Assets per bed in the nonprofit homes range from $18,000 to $28,000, with no significant variation by bed size (Table 12). These figures are several times the asset ratio of proprietary nursing homes where liabilities per bed are almost as great as assets per bed. The greater amount of assets per bed in the voluntary nursing homes may be accounted for by restricted endowment funds.

Public Skilled Nursing Homes

There were 37 public skilled nursing homes in New York State in 1972 plus an additional five operated by the Health and Hospitals Corporation in New York City for which no statistical data were available.

Unlike the private sector, none of the public homes was under 50 beds and as many as seven were over the size of 300.

Occupancy averaged 95.2 for the State and in almost all counties, occupancy exceeded 95 percent with a few exceptions where the rate dipped below 90 percent.

Over 95 percent of the patients in public skilled nursing homes were covered by Medicaid and in nine counties Medicaid accounted for 100 percent of the patients.

About one-third of the patients in such facilities were nonambulant with very wide variations among the counties, from a low of two percent to a high of 74 percent.

As with the private facilities, females accounted for a greater proportion of the residents — two-thirds of all patients. However the male age distribution revealed a considerably higher percentage in public homes who were under the age of 65 — 18.4 percent compared with 7.5 percent in voluntary facilities and 9.8 for proprietary facilities. The female age distribution was 10.3 for those under 65 compared with 3.3 in the voluntary homes and 5.2 in the proprietary facilities.

There were proportionately fewer of those age 85 and older in the public homes, 24.8 percent of males compared with 33.9 percent in the voluntary homes, and 26.6 percent in the proprietaries. Among females age 85 and over, a lower percentage was reported in the public homes compared with voluntary, 38.4 percent and 42.5 percent, respectively, but higher than the proprietary homes at 33.7 percent.

Of the total percentage discharged during the year, the highest amount was attributed to death, 42.3 percent compared with 35.4 percent in voluntary facilities and 30.5 percent in proprietary facilities. Public homes recorded the lowest percentage for discharge to own home, 8.1 percent compared with 17.6 percent in voluntary institutions and 16.6 percent in proprietary institutions. Those in public home infirmaries are frequently without families, have the highest proportion of Medicaid and generally have not been able to function independently in their own homes.

Amost 60 percent of patients in public facilities were admitted from hospitals, a higher amount than the 45.7 percent in voluntary homes but lower than the 71.2 percent in proprietary facilities.

The median length of stay — 8.9 months — was considerably longer than in private homes at 4 to 4.5 months which is understandable in view of the larger proportion of younger patients.

Health-Related Facilities

There were 144 health-related facilities in the State in 1972, accounting for 14,180 beds. Slightly more than one-third of these homes were under 50 beds, 30 percent were in the 50–99 size range, one-quarter were in the 100–199 range, and 11 percent were over 200 beds. The occupancy rate in health-related facilities was considerably lower than in skilled nursing homes at 82.5 percent. Some of these facilities were new and occupancy is generally low during the opening months of newly-opened homes. By county, the range in occupancy rate was from a low of 22 percent to a high of 98 percent.

There were 9,963 residents in such homes at the close of 1972, 71.4 percent of whom were covered by Medicaid. In New York City, Medicaid covered 76.3 percent of the patients. In Ulster, Clinton, Livingston, Orleans, Steuben, Wayne and Cattaraugus, 100 percent of the patients were covered by Medicaid. By contrast, Medicaid patients in Broome County accounted for only 40 percent of the total.

Health-related facilities do not provide the skilled nursing care which is available in nursing homes. Therefore it is not surprising that the percentage of nonambulatory patients is very low in such facilities. Many counties reported zero percent nonambulatory, with the State average at 1.5 percent. Only two counties reported a significant percentage of nonambulatory patients, Ontario and Clinton Counties, at 29 and 32 percent, respectively (Table 3).

Almost one-half of the beds were in the Southern New York region. There were only four such facilities which were over 300 beds, one in New York City, one in Westchester, one in Oneida County, and one in Monroe County.

Hospital-Based Facilities

By 1972 there were 54 hospital-based facilities providing skilled nursing care. Eighty percent of these facilities were under 100 bed size. Only two were located in New York City and 85 percent of the facilities were in Upstate New York.

Average occupancy in the State was close to 88 percent while in New York City a rate of over 97 percent was attained.

The percent covered by Medicaid was at 62.6 percent. This lower rate may be due to the fact that most of these patients, if not all, had been transferred from the hospital and were usually covered by Medicare if the medical need for skilled nursing care was indicated to the satisfaction of those officials reviewing Medicare utilization. In New York City, however, the Medicaid percentage was considerably higher at 98.5 percent. In Upstate New York, Medicaid accounted for only 59 percent of patients in hospital-based facilities. Of the 2,543 patients who were reported, almost three-quarters were in Upstate New York.

Reporting by hospitals for their nursing facilities has not been complete and the data cannot be considered reliable or conclusive.

EXHIBIT J

This rule is adopted as an emergency measure pursuant to the authority contained in paragraph (c) of subdivision 2 of section 202 of the State Administrative Procedure Act. I HEREBY FIND that it is necessary for the preservation of the general welfare to dispense with the requirements of notice and opportunity to present views and to file this order as an emergency measure and that conformance to the requirements of notice would not be in the public interest. The reason for these findings are as follows: The expenditures of the State Department of Social Services currently exceed budgeted amounts for the 1977 fiscal year, resulting in a potential threat to the State's ability to obtain financing including the financing of the Medicaid program. Inasmuch as expenditures for long term care facilities are the largest single identifiable component of that Department's expenditures, it is imperative that that methodology for computing rates for such facilities be altered so as to assure fiscal economies immediately. Additionally, in litigation currently pending, a lower court has determined that the current rates applicable to residential health facilities are invalid insofar as such rates are subject to a statutory mandate which preexisted the authority given in Chapter 76 of the Laws of 1976 and, in order to mitigate the potential threat of such a decision to the general welfare, it is necessary to promulgate this regulation immediately.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the New York State Department of Health to be affixed this 30th day of September, 1976. 67

Edward D. Coates

EDWARD D. COATES, M.D.
First Deputy Commissioner

STATE OF NEW YORK
DEPARTMENT OF STATE
FILED SEP 30 1976
Secretary of State

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

NEW YORK ASSOCIATION OF HOMES :
FOR AGING, INC.,

Plaintiffs, :

-against- :

PHILIP L. TOIA, as Commissioner of :
Social Services of the State of
New York, et al., :

Defendants. :

---X

NOTICE OF MOTION TO
DISMISS THE COMPLAINT
(R. 12[b][1][3][6].

76 Civ. 5113 (TPG)

SIRS:

PLEASE TAKE NOTICE that upon the Summons and Complaint and upon the annexed affidavits of Dr. Glenn E. Haughie, sworn to November 26, 1976; Donald B. Davidoff, sworn to November 26, 1976; and Dr. William Steibel, sworn to November 30, 1976, with exhibit annexed thereto, and upon the annexed affidavit of George C. Mantzoros, Assistant Attorney General, sworn to the 30th day of November, 1976, the undersigned will move this Court at a time for motions before Hon. Thomas Poole Griesa, United States District Court Judge, United States District Court for the Southern District of New York, to be held at the United States Courthouse, Foley Square, New York, New York, on the 2nd day of December , 1976, at 3:30 in the afternoon, or as soon thereafter as counsel can be heard for an order pursuant to Rules 12(b)(1)(3) and (6) dismissing the above entitled action; and for such other and further relief as the Court may deem just and proper, PLEASE TAKE FURTHER NOTICE that subject to the Court's approval, reply briefs and affidavits are to be served upon the undersigned at or before 5 P.M., December 1, 1976.

Dated: New York, New York
November 30, 1976

Yours, etc.

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for Defendants
By

George C. Mantzoros
GEORGE C. MANTZOROS
Assistant Attorney General
Office & P.O. Address
Two World Trade Center
New York, New York 10047
Tel. (212) 488-4298

TO: PROSKAUER ROSE MENDELSON & GOETZ, ESQS.
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---------------------------------------X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., :

Plaintiffs, :

-against- :

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al., :

Defendants. :

---------------------------------------X

AFFIDAVIT IN SUPPORT OF DEFENDANTS' CROSS MOTION TO DISMISS THE COMPLAINT (R. 12[b][1][3][6]) AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION.

76 Civ. 5113 (TPG)

STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

GEORGE C. MANTZOROS, being duly sworn, deposes and says:

1. I am an Assistant Attorney General in the office of LOUIS J. LEFKOWITZ, Attorney General of the State of New York, attorney for defendants. This affidavit is submitted in support of Defendants' Motion to Dismiss the Complaint (R. 12[b][1][3][6]) and in opposition to Plaintiffs' Motion for Preliminary Injunction. Plaintiffs' ultimatums and announcements of closing and termination of operations are tantamount to an illegal per se group boycott against the State to have their way to coerce and compel their self=serving method of payment upon the State.

2. Plaintiffs fail to demonstrate any real and compelling reason for a preliminary injunction. The plaintiff operators' failure to file a 90-day notice of intention to discontinue and to secure permission pursuant to 10 NYCRR §§401.3(f) 801.3(f) (see accompanying affid. of Dr. Haughie, Deputy Commissioner) demonstrates the absence of any "immediate irreparable injury" (Complaint par. 142) as plaintiffs purportedly allege.

We are constrained to contend - particularly in the absence of any presentation of financial data and an offer of an audit to ascertain out-of-pocket losses, if any -- that plaintiffs' allegations are in reality hypothetical and fanciful apprehensions. Dr. Haughie states the Department's responsibility to provide the "needed health resource" (par. 4). Injunctions, an extraordinary and drastic remedy, are not properly granted merely to allay fears and apprehensions. Without a showing of immediate and irreparable harm - which cannot possibly here be established -- plaintiffs have not sustained the additional burden by a convincing showing of a *prima facie* case and any likelihood of success; indeed, as demonstrated in the defendants' cross-motion to dismiss (Rules 12[b][1][3][6]), this action should be dismissed for lack of federal subject matter jurisdiction under 28 U.S.C. §§ 1331, 1343 (under the Civil Rights Act 42 U.S.C. 1983); improper venue in the Southern District of New York; failure to state a claim; and the lack of two plaintiff trade associations -- not owners or operators of nursing homes -- standing to sue. Moreover, under traditional principles of equity and in the public interest, in the context of announcements in combination -- like a group boycott -- should not receive judicial blessing for a clear violation of the New York Donnelly Anti-Trust Act and plaintiffs combination should not be permitted to call for the use of the strong arm of a Federal Court injunction to enforce their terms in the legislative-administrative forum -- which should remain free from any force or compulsion.

3. Plaintiffs fail to allege a *prima facie* constitutional claim. The four words "reasonable cost related basis" in the Medicaid Act § 1396(a)(13)(E), do not preempt New York's "methods and standards" developed pursuant to the mandate of Congress: "which shall be developed by the State."

No direct "conflict" is alleged or shown. Nor have plaintiffs alleged any of the traditional relevant criteria for any reasonable inference of specific congressional intent to preempt and supersede the State's development and implementation of "payment" by "methods and standards"; i.e., need of nationwide uniformity; conflict with administration of a federal statute; and pervasive federal regulation. The mandate of Congress directing that the "payment" upon "methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary" precludes and rebuts any inference of federal preemption of the State's regulations here challenged.

4. The "Provider Agreement" - a term of art - is not not like a commercial contract subject to constitutional protection against impairment or retroactivity. The New York Legislature by New York law incorporated therein, governs the terms, as it did in Chapter 76 of the Laws of 1976. Besides, as the undersigned is reliably informed, the original rates were published as interim and therefore subject to change. Accordingly, no valid constitutional claim predicated upon the Provider Agreement is here legally and sufficiently alleged.

5. This action - in essence an action against the State of New York - upon a bare contention that the New York regulations are "invalid" - a conclusion - is barred by the doctrine of sovereign immunity and by the Eleventh Amendment to the United States Constitution.

6. This Court lacks jurisdiction over the subject matter of this action (Rule 12 [b][1]). Sections 1331 and 1343 are not here relevant or applicable. There is no allegation

of a legally sufficient claim under the Civil Rights Act (42 U.S.C. 1983). Insofar as plaintiffs' claim relates to the subject of money -- property -- New York provides a forum to corporations for property compensation in the Court of Claims and for judicial review of administrative determinations (see Complaint Sixth-Twelfth Causes of Action) in the Supreme Court of the State of New York (N.Y.C.P.L.R. Art. 78). Section 1343 may not be used as a vehicle to raise claims of a monetary nature or to secure a competitive advantage in the State legislative-administrative forum. The operators have no vested right under the Medicaid Program to one particular method of payments.

8. 28 U.S.C. 1331 does not here confer federal jurisdiction in the absence of a federal question and the absence of the jurisdictional monetary amount ($10,000 or more). Contingent and speculative unproven monetary losses are insufficient. Besides, plaintiffs fail to allege any compliance as required by the New York Health Code, 10 N.Y.C.R.R.

9. Venue in the Southern District of New York was selected by plaintiffs notwithstanding that defendants and all the State's records and files are located in Albany, within the jurisdiction of the United States District Court for the Northern District of New York. Plaintiffs have heretofore confirmed that apart from the fact that some plaintiff owners are located upstate in Ilion, New York (Complaint par. 9), Albany, New York (id. par. 10), and Syracuse, New York (id. par. 11), the membership of the two trade associations (one in Albany) are "located in Westchester, Queens and other counties in the State of New York" (affd. Jeffrey A. Mishkin, November 23, 1976 in venue motion). We have not made "vague and conclusory

allegations" as plaintiffs have heretofore contended as evidenced by the fact that the undersgined has been communicating by telephone and by a two or three-day courier service with defendants' staffs in Albany - not in New York City. Furthermore, the undersigned has attended a few conferences in the action pending before United States District Judge Morris E. Lasker and it is noted that depositions of defendants and their staffs and inspection of documents took place in Albany - not in New York City. Splitting of a preparation for trial - if a trial is here required - unnecessarily imposes additional time, effort and expenses and sacrifices quality for speedy and accelerated discovery. Generally, State like Federal law offices cannot assign teams of attorneys by reason of the large caseloads. Plaintiffs alternate suggestions that discovery can be handled in Albany is not helpful to the undersigned in New York City as trial counsel.

WHEREFORE, defendants respectfully request that their motion to dismiss the action be granted in all respects and that plaintiffs' motion for preliminary injunction be denied in all respects with costs.

George C. Mantzoros
GEORGE C. MANTZOROS

Sworn to before me this
30th day of November, 1976

Assistant Attorney General
of the State of New York

allegations" as plaintiffs have heretofore contended as evidenced by the fact that the undersgined has been communicating by telephone and by a two or three-day courier service with defendants' staffs in Albany - not in New York City. Furthermore, the undersigned has attended a few conferences in the action pending before United States District Judge Morris E. Lasker and it is noted that depositions of defendants and their staffs and inspection of documents took place in Albany - not in New York City. Splitting of a preparation for trial - if a trial is here required - unnecessarily imposes additional time, effort and expenses and sacrifices quality for speedy and accelerated discovery. Generally, State like Federal law offices cannot assign teams of attorneys by reason of the large caseloads. Plaintiffs alternate suggestions that discovery can be handled in Albany is not helpful to the undersigned in New York City as trial counsel.

WHEREFORE, defendants respectfully request that their motion to dismiss the action be granted in all respects and that plaintiffs' motion for preliminary injunction be denied in all respects with costs.

GEORGE C. MANTZOROS

Sworn to before me this
30th day of November, 1976

Assistant Attorney General
of the State of New York

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC. MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities which render services to Medicaid-sponsored patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

AFFIDAVIT IN OPPOSITION

76 Civ. 5113

STATE OF NEW YORK) ss.
COUNTY OF ALBANY)

GLENN E. HAUGHIE, M.D., being duly sworn, deposes and says:

1. He is Deputy Commissioner for Health Care Standards, Department of Health of the State of New York, and makes this affidavit in opposition to the application of the plaintiffs for a preliminary injunction.

2. Prior to the statements made in the affidavits in support of the application, to your deponent's knowledge, neither the deponent nor the Department of Health had received any indication from the named residential health care facilities of an intent to cease operation.

3. The State Hospital Code prohibits a medical facility from discontinuing operation or surrendering its operating certificate unless it gives the Commissioner of Health 90 days

notice of its intention to do so and obtain its written approval (10 NYCRR §§ 401.3 (f), 801.3 (f)).

4. It would not be consonant with the interests of the Department of Health and the people of the State of New York that facilities representing a needed health resource be given approval to cease operation.

5. The fact that neither the Department of Health nor the State are to be considered as being in a competitive or adversary situation vis-a-vis the plaintiff facilities must be emphasized. It is not part of the State's plan for the provision of adequate health resources that facilities which constitute part of those resources close their doors to those in need of the care those facilities are providing. Both the plaintiff facilities and the State of New York are confronted with financial difficulties arising out of the same economic climate but the State is not using a fiscal crisis to close residential health care facilities.

6. The affidavits in support of the application for a temporary injunction contain conclusory statements that the 1976 rates will not reimburse the facilities their reasonable costs. The moving papers are entirely devoid of any financial data in support of such claims. It is not asserted that the named non-profit residential health care facilities will sustain any actual out-of-pocket losses as a result of the promulgated 1976 rates. Such losses can only be shown by financial statements which are then subject to verification by audit procedures.

7. It is the intent of the State to remain in compliance with all requirements for full participation in the federal Medicaid program (Title XIX of the Social Security Act). To your deponent's knowledge, there is no conflict between State

law and the provisions of Title XIX and regulations pursuant thereto and now in effect applicable to residential health care facilities. The affidavit of Donald B. Davidoff, Associate Director, Division of Health Care Financing of the New York State Department of Health, deals with this aspect in greater detail.

8. In the absence of any conflict with Federal law and the Constitution of the United States and any factual demonstration of immediate and irreparable injury, the application for a preliminary injunction should not be granted.

Sworn to before me this
26th day of November 1976

Glenn E. Haughie MD
Glenn E. Haughie, M.D.

Notary Public

DONALD A. [illegible]
Notary Public, State of New York
Residing in Albany County
Commission Expires March 30, 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES
FOR AGING, INC., HOSPITAL ASSOCIATION
OF NEW YORK STATE, INC., ST. CABRINI
NURSING HOME, INC., MARGARET TIETZ
CENTER FOR NURSING CARE, INC., MOHAWK
VALLEY NURSING HOME, INCORPORATED,
DAUGHTERS OF SARAH NURSING HOME CO., INC.,
AND LORETTO REST NURSING HOME CO., INC.,
on behalf of themselves and all other
nonprofit residential health care
facilities which render services to
Medicaid-sponsored patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of
Social Services of the State of New York,
ROBERT P. WHALEN, as Commissioner of
Health of the State of New York,
PETER GOLDMARK, as Director of the
Budget of the State of New York, and
HUGH L. CAREY, as Governor of the
State of New York,

Defendants.

AFFIDAVIT
IN OPPOSITION

76 Civ. 5113

STATE OF NEW YORK) ss.
COUNTY OF ALBANY)

DONALD B. DAVIDOFF, being duly sworn, deposes and says:

1. He is the Associate Director, Division of Health Care Financing of the New York State Department of Health, and makes this affidavit in opposition to the application of the plaintiffs for a preliminary injunction.

2. The 1976 Medicaid reimbursement rates for residential health care facilities are in compliance with all applicable Federal and state laws and rules.

3. Regardless of the actual effective date of the Federal requirement that long term care rates be developed on a reasonable cost related basis, the New York State 1976 method meets the stated criteria. In fact, since 1966 New York State has allowed nursing home reimbursement to be cost based.

4. The 1976 rates were based on 1974 costs of each residential health care facility, subject to ceilings and disallowances, and trended forward into 1976. The ceilings for 1976 were developed as percentiles of the per diem range of costs of facilities receiving the same service rating for each of 6 specific functions: nursing, food-nutrition, leisure-time activities, cleanliness and safety, social work, and administration. The described approach is mandated by Chapter 76 of the Laws of 1976. The permissible percentile ranges are based on the rating (also required by Chapter 76) each facility received for rendering the services in the functional areas.

5. I am aware of the Department of HEW statements found in the July 1, 1976 issue of the Federal Register (41) which seem to be contrary to our approach. The HEW material was intended to offer guidelines to the states in their development of rates on a reasonable cost related basis. Specifically, HEW would not permit a state to reimburse at, for example, 60% of a facility's costs. Our method does not work in that fashion. Rather, we establish the lowest rate in each group as the reasonable cost base, and we permit facilities to exceed our lowest cost denominator on a ceiling basis.

6. The existence of actual expended costs is by no means synonymous with reasonable costs. Both Federal and state law anticipate the development of a method of reimbursement that is based on costs, but which may limit liability to a reasonable level below actual costs.

Donald B. Davidoff

Sworn to before me this
26th day of November, 1976

Notary Public

[illegible]
Notary Public, State of New York
Residing in Albany County
Commission Expires March 30, 1977

204

FILE 76-51

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, NEW YORK 12243

PHILIP L. TOIA
COMMISSIONER
WILLIAM STEIBEL
DEPUTY COMMISSIONER

September 29, 1976

Mr. Seymour Budoff
Associate Regional Commissioner
for Medical Services
Department of Health, Education, and
Welfare
26 Federal Plaza
Room 3542
New York, NY 10007

HAND DELIVERED
TO ADDRESSEE
9-29-76
J.

Dear Sy:

As I have indicated to you in our recent telephone conversations, New York State has developed a revised methodology for establishing skilled nursing home and intermediate care facilities payment rates which require that individual rates which are related to cost be determined for individual facilities.

Because our current State law requiring this revision is, by its express terms, retroactive to January 1, 1976, the question has been raised as to whether there is any apparent impediment, in terms of Federal statutory or regulatory requirements, to this State's adoption of revised rates on a retroactive basis. You have indicated in our recent conversations that the specific methodology for nursing home and intermediate care facility rates is not part of our Title XIX State Plan, and therefore, revisions in the methodology do not require DHEW approvals. In light of the substantial Federal financial participation involved, and the numerous law suits relating to this and similar issues, I am requesting your written opinion as to the necessity for obtaining Federal approvals of the revised methodology [illegible]

We of course intend to submit amendments to plan material as necessary when changes to Section 249 of Federal regulations take effect.

Thank you for your cooperation in this matter.

Sincerely,

S/9-29

William Steibel

WS/jd

Ex. 1

Ex. 1

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007

SOCIAL AND REHABILITATION SERVICE

SEP 30 1976

William Steibel, D.D.S.
Deputy Commissioner
Division of Medical Assistance
New York State Department of
Social Services
1450 Western Avenue
Albany, New York 12243

Dear Bill:

This is in response to your September 29, 1976 letter in which you raised the question as to whether there are any restrictions in terms of statutory or regulatory requirements to New York adopting a revised rate for SNFs and ICFs on a retroactive basis.

As you know, regulations published July 1, 1976 (45 CFR 250.30 (a)(3)) require that effective July 1, 1976, payment for skilled nursing facility and intermediate care facility services must be on a reasonable cost-related basis. HEW's role in the rate-setting process is to approve and verify the methods of cost-finding established by the State. Approval of cost-finding methods takes place when State Plan amendments are submitted. The revised pages and attachments to the Title XIX State Plan are due in the Regional Office by December 31, 1976. The plan material must indicate compliance with the specific effective dates set forth for cost reporting periods, auditing activities, and payment of rates developed under the State's methods.

Prior to the publication of the July 1, 1976 regulations, there was no specific methodology of reimbursement required for SNFs and ICFs in the Title XIX State plan. The regulations (45 CFR 250.30(b)(3)(B)) provided that the State established schedules of charges which were consistent with the intent that upper limits did not exceed amounts paid under Title XVIII for similar services.

BEST COPY AVAILABLE

Ex. 2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC. MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities which render services to Medicaid-sponsored patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

AFFIDAVIT IN OPPOSITION

76 Civ. 5113

STATE OF NEW YORK)
COUNTY OF ALBANY) ss

WILLIAM STEIBEL, D.D.S., being duly sworn, deposes and says:

1. I am the Deputy Commissioner, Division of Medical Assistance, of the New York State Department of Social Services (hereinafter Social Services) and I make this Affidavit in Opposition to Plaintiffs' application for a preliminary injunction.

2. Plaintiffs challenge the legality of Regulations of the New York State Department of Health (hereinafter Health) contained in 10 NYCRR Part 88. These regulations set out a methodology whereby individual rates of medicaid reimbursement are computed for residential health care facilities.

3. Pursuant to Section 363-a of the Social Services Law, Section 1902(a)(2) of the Social Security Act and 45 CFR 205.100(a), Social Services has been designated as the single state agency supervising the administration of the New York State Medicaid (Title XIX)Program. Pursuant to Section 364 and 364-a of the Social Services Law and agreements entered into thereunder, Health computes and promulgates rates for Medicaid reimbursement to residential health care facilities. Health utilizes the procedure set forth in Public Health Law 2808 and 18 NYCRR Part 88 to compute and promulgate these rates.

4. On or about September 29, 1976, Health promulgated new rates for residential health care facilities. Upon approval by the director of the budget, said rates were distributed to local social services districts by this Department pursuant to its obligations under the law.

5. A group of petitioners purporting to represent a class of all nursing homes in New York State has challenged said new rates in a New York State Supreme Court proceeding entitled Leslie Kaye d/b/a Sans Souci Nursing Home et al v. Toia et al. Therefore, it would appear to be superfluous and duplicative for the United States District Court to entertain an action on the same issues.

6. Plaintiffs allege in this action that said rates promulgated by Health are in some way intended to penalize all nursing homes and were promulgated with the knowledge that these rates will force some facilities to close. Moreover it is alleged that the rate setting methodology and the rates themselves violate State and Federal law.

7. The information available to deponent establishes that Health designed the structure here in issue to provide adequately for plaintiffs' reasonable costs and encourage high quality residential health care facility services while at the same time requiring cost efficiency pursuant to Public Health Law Section 2808.

8. There is no intention by Social Services to impair high quality residential health care facility services and certainly no intention by any means, implied or otherwise, to force a general closing of facilities providing quality care.

9. The Department of Health, Education and Welfare has had an opportunity to review the regulations here in issue as recently as September 30, 1976. At that time, this Department was assured by the Department of Health, Education and Welfare that its Title XIX Plan (Medicaid) was in compliance with federal standards insofar as its reimbursement system to residential health care facilities was concerned. (See letter of William Steibel to Seymour Budoff dated September 29, 1976 attached hereto as Exhibit I and Mr. Budoff's reply attached hereto as Exhibit II)

10. Plaintiffs assert they are entitled to relief under 1902(a)(13)(E) of the Social Security Act which provides for federal standards of cost relatedness. In fact, however, implementation of said provision has been postponed by Department of Health, Education and Welfare until no earlier than January 1, 1977 (See Exhibit II attached).

11. It follows then that the regulations in issue pose no violation to Federal or State law.

12. Plaintiffs allege substantial financial loss as a result of the rate structure here in issue, yet they make no showing of same other than broad conclusive statements.

13. Plaintiffs claim that the new rates, which for some facilities are the same or lower than the 1975 rates, must result in financial loss for these facilities because of the general inflation experienced nationwide over the last few years. It is my opinion that this conclusion does not necessarily follow. Inflation may not affect a particular residential health care facility in the same manner or to the same extent that it affects the population at large. Furthermore, residential health care facilities may be able to take steps to avoid financial loss under the new rates despite the existence of continuing inflation without any decrease in their ability to provide high quality medical care. The elimination of unnecessary expenses, a more diligent effort in purchasing supplies and equipment at lower costs, an improvement in the efficiency and organization of staff, and other accepted business techniques can be used to

avoid financial loss despite inflation without a decrease in the quality of care.

14. By failing to show, by direct and explicit proof, that actual out-of-pocket losses will be suffered by plaintiffs, they have not shown they will suffer irreparable injury. For this reason and because no violation of federal law, the U.S. Constitution or state law exists, the relief requested by plaintiffs should be denied.

William Steibel

WILLIAM STEIBEL, D.D.S.

Sworn to before me this
30 day of November, 1976.

Jonathan M Brandes

NOTARY PUBLIC

JONATHAN M. BRANDES
Notary Public in the State of New York
Qualified in Albany County
No. 4507369
My Commission expires March 30, 19.77

FILE 76-51

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, NEW YORK 12243

PHILIP L. TOIA
COMMISSIONER
WILLIAM STEIBEL
DEPUTY COMMISSIONER

September 29, 1976

Mr. Seymour Budoff
Associate Regional Commissioner
for Medical Services
Department of Health, Education, and
Welfare
26 Federal Plaza
Room 3842
New York, NY 10007

HAND DELIVERED
TO ADDESSEE
9-29-76
J. Brandes

Dear Sy:

As I have indicated to you in our recent telephone conversations, New York State has developed a revised methodology for establishing skilled nursing home and intermediate care facilities payment rates which require that individual rates which are related to cost be determined for individual facilities.

Because our current State law requiring this revision is, by its express terms, retroactive to January 1, 1976, the question has been raised as to whether there is any apparent impediment, in terms of Federal statutory or regulatory requirements, to this State's adoption of revised rates on a retroactive basis. You have indicated in our recent conversations that the specific methodology for nursing home and intermediate care facility rates is not part of our Title XIX State Plan, and therefore, revisions in the methodology do not require DHEW approvals. In light of the substantial Federal financial participation involved, and the numerous law suits relating to this and similar issues, I am requesting your written opinion as to the necessity for obtaining Federal approvals of the revised methodology under our existing Title XIX State Plan.

We of course intend to submit amendments to plan material as necessary when changes to Section 249 of Federal regulations take effect.

Thank you for your cooperation in this matter.

Sincerely,

5/9-27

William Steibel

WS/jd

EXHIBIT I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007

SOCIAL AND REHABILITATION
SERVICE

SEP 30 1976

William Steibel, D.D.S.
Deputy Commissioner
Division of Medical Assistance
New York State Department of
Social Services
1450 Western Avenue
Albany, New York 12243

Dear Bill:

This is in response to your September 29, 1976 letter in which you raised the question as to whether there are any restrictions in terms of statutory or regulatory requirements to New York adopting a revised rate for SNFs and ICFs on a retroactive basis.

As you know, regulations published July 1, 1976 (45 CFR 250.30 (a)(3)) require that effective July 1, 1976, payment for skilled nursing facility and intermediate care facility services must be on a reasonable cost-related basis. HEW's role in the rate-setting process is to approve and verify the methods of cost-finding established by the State. Approval of cost-finding methods takes place when State Plan amendments are submitted. The revised pages and attachments to the Title XIX State Plan are due in the Regional Office by December 31, 1976. The plan material must indicate compliance with the specific effective dates set forth for cost reporting periods, auditing activities, and payment of rates developed under the State's methods.

Prior to the publication of the July 1, 1976 regulations, there was no specific methodology of reimbursement required for SNFs and ICFs in the Title XIX State plan. The regulations (45 CFR 250.30(b)(3)(B)) provided that the State established schedules of charges which were consistent with the intent that upper limits did not exceed amounts paid under Title XVIII for similar services.

EXHIBIT II

G. MONTZOROS

Page 2

As you can see, our regulations have not previously required DHEW approval of the reimbursement methodology developed by the States for SNFs and ICFs. Therefore, revisions to rates for periods prior to the implementation of 250.30(a)(3), (December 31, 1976) are not contrary to Federal regulations insofar as they meet the test of not exceeding amounts paid under Title XVIII.

Sincerely,

Seymour L Budoff

Seymour Budoff
Associate Regional Commissioner

Rec'd 12/2

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC.,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al.,

Defendants.

---X

SUPPLEMENTAL AFFIDAVIT

76 Civ. 5113
(TPG)

STATE OF NEW YORK)
: SS.:
COUNTY OF NEW YORK)

GEORGE C. MANTZOROS, being duly sworn, deposes and says:

1. I am an Assistant Attorney General in the office of LOUIS J. LEFKOWITZ, Attorney General of the State of New York, attorney for defendants. This supplemental affidavit is submitted in support of the defendants' motion to dismiss the action (R. 12[b][1][3][6]) and in opposition to plaintiff's motion for preliminary injunction.

2. A "Medicaid Provider and the Supplemental Affidavit of Donald B. Damdoff, sworn to December 1, 1976, are annexed hereto as part of this record.

3. Chapter 76 of the Laws of 1976 does not impair the obligation of a contract -- the "Provider Agreement" which thus generally refers to the consideration "in consideration of receiving payments for services provided to individuals receiving

assistance under the New York State Plan for Medical Assistance***" (emphasis added). No reimbursement payment or rate of payment is fixed in said "Provider Agreement". See LaCrescent Constant Care Center, Inc. v. State of Minnesota, 222 N.W. 2d 87, 91 (Sup. Ct. Minn. 1974) where the Court found that the State's action in freezing a reimbursement rate was not arbitrary or capricious since the "contractual relationship between nursing homes and the state is unique in that no reimbursement figure, be it a fixed per diem rate or schedule of maximum fees, is provided in the contract."

4. Besides, Article 1, Section 10 of the United States Constitution does not provide an absolute prohibition. Home Building & Loan Ass'n v. Blaisdell, 290 U.S. 398 (1934); City of El Paso v. Simmons, 397 U.S. 497 (1965) reh. denied, 380 U.S. 926). Even assuming arguendo, any possible impairment, the State's legislation is permissible in furtherance of a legitimate and including an economic situation. Totten v. Saionz, 38 A D 2d 630 (3d Dept., 1971); Blaisdell, supra. Chapter 76 of the Laws of 1976 declares a policy (§ 1): "***a state of emergency exists and hereby confers emergency powers on the governor to take such steps as are necessary to implement the following controls on medical assistance and public assistance expenditures". The methodology here challenged on constitutional grounds was pursuant to State legislative direction. Insofar as there is retroactive application pursuant to legislature direction which is permissible (Jacobus v. Colgate, 217 N Y 2d 275), the alleged retroactive application by statute does not invalidate such statute. 2 Sutherland Statutory Construction (4th ed.) § 41.03; McKinney's Statutes, § 51, p. 92.

5. Under a cost efficiency program, nursing home owners and operators can and should be able to provide the quality care required by the State and to which our Senior Citizens are entitled. If, in fact, they do not do so, such inability is necessarily attributable to a failure to adopt cost efficency measures and procedures in procurement of goods and services, etc. In the event of an exceptional situation - proven by audit - there are available administrative review procedures in the Department of Health for such contingency.

WHEREFORE, defendants respectfully request that the motion to dismiss be granted and plaintiff's motion for preliminary injunction be denied.

GEORGE C. MANTZOROS

Sworn to before me this
2nd day of December, 1976

Assistant Attorney General
of the State of New York

NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROVIDER AGREEMENT

(FULL COMPLIANCE)

The undersigned, certified by the Secretary of the Department of Health, ducation, and Welfare, as eligible for Title XIX (Medicaid) agreement, shall e subject to the same terms and conditions and coterminous with the approval f eligibility as specified by the Secretary pursuant to Title XVIII, for a TWELVE-- month term as being in full compliance with the standards of a 'Skilled Nursing Home" as defined in Part 249 of Title 45 of the Code of ederal Regulations, in consideration of receiving payments for services rovided to individuals receiving assistance under the New York State Plan for Medical Assistance pursuant to Title XIX of the Social Security Act, ereby agree(s) as follows:

a. To keep such records as are necessary fully to disclose the extent of the services provided to such individuals receiving assistance under the said plan and

b. To furnish the New York State Department of Social Services with such information regarding any payments claimed by the nursing home for providing such services as the Department may from time to time request and

c. To insure that established written policies and practices governing admission and retention of patients within the facility reflect full compliance with regard to the provisions of Title VI of the Civil Rights Act of 1964 and additionally do not discriminate as to source of payment in admission and retention of patients in said facility.

This agreement shall continue in effect for the term indicated below and no longer, so long as the nursing home continues to be certified by the New York State Department of Health as being in full compliance with the standards of a "skilled nursing home" as defined in Part 249 of Title 45 of the Code of Federal Regulations and so long as the nursing home continues to provide services in accordance with applicable provisions of the Social Services Law of the State of New York, the Public Health Law, the rules and regulations of the Department of Social Services and the requirements of the State Hospital Code.

This coterminous agreement is not transferable or assignable.

Nothing herein shall be construed to limit or alter any contract between the undersigned and any State or Federal agency.

Appendix "A"

MEDICAID PROVIDER AGREEMENT (FULL COMPLIANCE)

Effective Date: June 1, 1975 Expiration Date: May 31, 1976

Termination of your Title XVIII certification, by reason of non-compliance with the uniform conditions of participation, or voluntary withdrawal from Title XVIII will nullify your Title XIX Provider Agreement, effective the date of such termination or withdrawal.

EDP Identification # 729

Mr. Leslie Kaye, Administrator
SANS SOUCI NURSING HOME
115 Park Avenue
Yonkers, New York 10703
Name and Address of Nursing Home

120 beds

Leslie Kaye
Authorized Signature

Date: 5/14/75

Receipt acknowledged for the New York State Department of Social Services

by: Thomas Fitzpatrick 5/19/75
Name Date

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES
FOR AGING, INC., HOSPITAL ASSOCIATION
OF NEW YORK STATE, INC., ST. CABRINI
NURSING HOME, INC., MARGARET TIETZ
CENTER FOR NURSING CARE, INC., MOHAWK
VALLEY NURSING HOME, INCORPORATED,
DAUGHTERS OF SARAH NURSING HOME CO., INC.,
AND LORETTO REST NURSING HOME CO., INC.,
on behalf of themselves and all other
nonprofit residential health care
facilities which render services to
Medicaid-sponsored patients,

Plaintiffs,

- against -

PHILIP L. TOIA, as Commissioner of
Social Services of the State of New York,
ROBERT P. WHALEN, as Commissioner of
Health of the State of New York,
PETER GOLDMARK, as Director of the
Budget of the State of New York, and
HUGH L. CAREY, as Governor of the
State of New York,

Defendants.

AFFIDAVIT IN OPPOSITION

76 Civ. 5113

STATE OF NEW YORK) ss.
COUNTY OF ALBANY)

DONALD B. DAVIDOFF, being duly sworn, deposes and says:

1. He is the Associate Director, Division of Health Care Financing of the New York State Department of Health, and makes this affidavit in opposition to the application of the plaintiffs for a preliminary injunction.

2. The decision to implement the reimbursement rates immediately, and retroactive to January 1, 1976, is mandated by Chapter 76, and there is no 60 day notice requirement applicable to rates from January 1, 1976 through March 31, 1976.

3. Bill section 11 of Chapter 76, among other things, establishes a time frame for Medicaid residential health care facility reimbursement. The statutory rate period begins January 1, 1976 and ends March 31, 1977. (§2807(2)(e)) Section 11 took effect immediately: March 30, 1976.

4. Bill section 16 in effect repealed the former 60 day notice rule "from and after November 1, 1975."

5. Bill section 13 added a new 60 day notice rule with an immediate effective date. Therefore, the former rule is gone, and the new rule applies to a future established rate period.

6. It is not likely that the Legislature would enact a retroactive rate cycle, and then require that 60 days notice be given before the rates could become effective. Such a result is in fact inconsistent and strained. The entire tone of Chapter 76 is that "a state of emergency exists" and that emergency powers are necessary to control Medicaid and other welfare expenditures.

7. The conclusion is inescapable that there is no 60 day notice rule applicable to the 15 month rate period.

8. Plaintiffs cite Hurlbut v. Whalen (decided October 29, 1976 -- Monroe County Supreme Court) as authority to the contrary. The Hurlbut case is on appeal. It did not involve Chapter 76 calculated rates, nor did the Court take judicial notice of Chapter 76. Furthermore, since passage of the former 60 day notice rule in 1974, there has never been a single situation where individual rate changes, such as in Hurlbut, were subjected to the 60 day rule. The intent of the original rule, and it has been uniformly so administered, was that it applied only to the basic "start up" set of annual rates -- not to the hundreds of adjusted rates that, for a variety of reasons, are promulgated every year.

Donald B. Davidoff

Sworn to before me this
1st day of December, 1976

Notary Public

DONALD A. MacHARG
Notary Public, State of New York
Residing in Albany County
Commission Expires March 30, 1977

221

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

--X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., et al.,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al.,

Defendants.

--X

76 Civ. 5113
(TPG)

ived
Received
tered in Docket
tered in Diary For

SUPPLEMENTARY AFFIDAVIT IN OPPOSITION

William F. McCann, being duly sworn, deposes and says:

1. He is Assistant Commissioner for the Division of Health Care Financing in the New York State Department of Health and makes this affidavit in opposition to the motion for a preliminary injunction herein.

2. According to the records of the Division of Health Care Financing, there are 286 non-profit residential health care facilities in the State.

3. The records of the Division of Health Care Financing show that the rates issued November 1, 1976 for the period January 1 - December 31, 1976 for said 286 facilities increased the reimbursement rates of 103 of the facilities, decreased the rates of 176 and remained the same for seven in comparison with the prior interim rates.

4. With respect to Mohawk Valley Nursing Home, Incorporated, one of the named plaintiffs herein, a review of the rate computations shows the new rate for the facility to be $ 42.96 instead of $ 28.96.

5. The Department of Health is prepared to entertain appeals by members of the plaintiff class if supported by data specified in 10 NYCRR 86-2.14, with priority of review according to the degree of adverse effect occasioned by the new rates.

William F. McCann
William F. McCann

Sworn to before me this
8th day of December, 1976.

Notary Public

Served
Filed Received [illegible]
Entered in Docket
Entered in Diary For

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., et al.,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al.,

Defendants.

76 Civ. 5113
(TPG)

SUPPLEMENTAL AFFIDAVIT OF MITCHELL WAIFE

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

MITCHELL WAIFE, being duly sworn, deposes and says:

1. I am a vice president of the New York Association of Homes for Aging, Inc. (NYAHA), and I submit this supplemental affidavit in support of plaintiffs' motion for a preliminary injunction.

2. It has been demonstrated that the implementation of the new reimbursement rates as of November 1, 1976 will result in substantial prospective cash losses for each of the five named plaintiffs. The purpose of this affidavit is to demonstrate that such losses are typical of those which will be caused to residential health care facilities throughout the State if the new reimbursement rates are implemented as of November 1, 1976.

3. Annexed hereto as Exhibit 1 is Hospital Memorandum Series 76-6, dated 1/9/76, from the Department of Health, which contains a listing of the Medicaid reimbursement rates for residential health care facilities effective January 1, 1976. These rates, in virtually all cases, were identical to the rates paid in 1975.

4. Annexed hereto as Exhibit 2 is Hospital Memorandum Series 76-116, dated 10/31/76, from the Department of Health, which contains a listing of the Medicaid reimbursement rates for residential health care facilities effective November 1,1976 and purporting to be retroactive to January 1, 1976. (This Hospital Memorandum has been marked in evidence as Plaintiffs' Exhibit 3 and is resubmitted here for the Court's convenience.)

5. An analysis of the two Hospital Memoranda referred to above shows that of the 219 nonprofit residential health care facilities listed, 138 suffered reductions in their new reimbursement rates. Annexed hereto as Exhibit 3 are schedules prepared under my direction listing each of the nonprofit residential health care facilities that has suffered a reduction in its new rate and the amount of the reduction per patient day.

6. On December 20, 1976, in accordance with the direction of the Court on December 17, 1976, I and other representatives of nonprofit residential health care facilities telephoned 20 nonprofit residential health care facilities located throughout New York State to determine the financial losses that would be incurred by these

facilities for November and December 1976 alone if the new rates were implemented. Annexed hereto as Exhibit 4 is a schedule reflecting the information received in our telephone conversations.

MITCHELL WAIFE

Sworn to before me this
20thday of December, 1976.

Notary Public

JEFFREY A. MISHKIN
NOTARY PUBLIC, State of New York
No. 31-4507312
Qualified in New York County
Commission Expires March 30, 1977

38050
012

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

--X

NEW YORK ASSOCIATION OF HOMES FOR :
AGING, INC., et al.,

Plaintiffs, :

-against- : **DEFENDANTS' ANSWER**

PHILIP L. TOIA, as Commissioner of : 76 Civ. 5113
Social Services of the State of New (TPG)
York, et al., :

Defendants. :

--X

Defendants, by their attorney, LOUIS J. LEFKOWITZ, Attorney General of the State of New York, for an answer to the complaint, respectfully allege:

1. Deny each and every allegation contained in paragraph 1 and subparagraphs (A), (B) and (C), except admit that the action purports to be brought as a class action for a declaratory judgment, for preliminary and injunctive relief to enjoin certain rates referred to therein and to declare illegal and to enjoin certain regulations referred to therein under which the challenged rates were calculated, and, refer to the specified statutes and regulations for their provisions and terms.

2. Deny each and every allegation contained in paragraph 2.

3. Deny each and every allegation contained in paragraph 3, except admit that this action purports to arise under specified constitutional provisions and statutes.

4. Deny each and every allegation contained in paragraph 4, except admit that the jurisdiction of the Court and venue purport to be invoked under the specified statutes.

5. Deny knowledge and information sufficient to form a belief as to the truth of the allegations of paragraphs 5 and 6.

6. Deny each and every allegation contained in paragraph 12, except admit that the plaintiffs purport to bring this action pursuant to Rules 23(a) and 23(b)(2) of the Federal Rules of Civil Procedure.

7. Deny each and every allegation contained in paragraphs 13, 14, 15 and 16.

8. Deny each and every allegation contained in paragraph 17, except admit that Philip L. Toia is Commissioner of the Department of Social Services of the State of New York and refer to the New York Social Services Law for its provisions.

9. Deny each and every allegation contained in paragraph 18, except admit that Robert P. Whalen is the Commissioner of the Department of Health of the State of New York and refer to the New York Public Health Law for its provisions.

10. Deny each and every allegation contained in paragraph 19, except admit that Peter Goldmark is the Director of the Budget of the State of New York and refer to the New York Public Health Law for its provisions.

11. Deny each and every allegation contained in paragraph 20, except admit that Hugh L. Carey is the Governor of the State of New York and that as Governor he has certain powers and duties and refer to the Constitution and statutes of the State of New York setting forth those powers and duties.

BEST COPY AVAILABLE

12. Deny knowledge and information sufficient to form a belief as to the truth of the allegations contained in paragraphs 21-46 and refer to each specified constitutional, statutory and regulatory provision and to each document referred to therein for their provisions and terms.

13. Deny each and every allegation contained in paragraphs 47, 48 and 49.

14. Deny knowledge and information sufficient to form a belief as to the truth of the allegations contained in paragraphs 50, 51, 52, 53, 54, 55, 56 and 57 and refer to each specified constitutional, statutory and regulatory provision and judicial determination and each document referred to therein for their contents, provisions and terms.

15. Deny each and every allegation contained in paragraph 57.

16. Deny each and every allegation contained in paragraph 58, except admit that pursuant to the directive of Chapter 76 of the Laws of 1976, the Department of Health established ratings between on or about May 14, 1976 and June 30, 1976, for residential health care facilities in the State of New York.

17. Deny each and every allegation contained in paragraph 60 and subparagraphs (A), (B) and (C), except admit that ratings were based upon reports of the Department of Health surveyors who inspected the facilities and as to subparagraph (B), reference is made to the relevant provisions of Chapter 76 of the Laws of 1976.

18. Deny each and every allegation contained in paragraphs 62.

19. Deny knowledge and information sufficient to form a belief as to the truth of the allegations of paragraph 64.

20. Deny each and every allegation contained in paragraph 65.

21. Deny each and every allegation contained in paragraphs 66, 67 and subparagraphs (A), (B) and (C), 68 and subparagraphs (A), (B) and (C), 69, 70 and 71, except admit that the Department of Health developed regulations pursuant to and in accordance and compliance with the legislative mandate in Chapter 76 of the Laws of 1976 and refer to each specified statute and regulations for its provisions and terms.

22. Deny each and every allegation contained in paragraphs 72-77, except admit that Part 88 of 10 NYCRR was filed by the Department of Health with the Secretary of State on or about September 30, 1976, and that 1976 Medicaid reimbursement rates were approved by the Director of the Budget on or about October 26, 1976, and that its successor, Part 86-2 of 10 NYCRR, was filed by the Department of Health with the Secretary of State on or about November 29, 1976, and refer to each specified statute and regulation for its provisions and terms.

23. Deny each and every allegation contained in paragraphs 78-82, except admit that in some instances new rates were lower than the 1975 rates and in some instances the new rates were higher than the 1975 rates.

24. Deny each and every allegation contained in paragraphs 83-85, except admit that defendants claim that they are entitled to recoup any amounts due from plaintiffs and other non-profit residential health care facilities as a result of adjustments in rates.

25. Deny each and every allegation contained in paragraph 87.

26. Deny each and every allegation contained in paragraph 89, except admit that a Medicaid Provider Agreement has been executed between each residential health care facility and the Department of Social Services and refer to the terms of each agreement.

27. Deny each and every allegation contained in paragraph 90.

28. Deny each and every allegation contained in paragraph 92, except admit that Medicaid Provider Agreements have been executed and refer to the terms of each Agreement and to the provisions of the specified New York Hospital Code and CFR § 250.30(a)(8).

29. Deny each and every allegation contained in paragraph 93.

30. Deny each and every allegation contained in paragraph 95, except refer to 45 CFR § 250.30(a)(7) for its provisions and terms.

31. Deny each and every allegation contained in paragraphs 96 and 97.

32. Deny knowledge and information sufficient to form a belief as to the truth of the allegations of paragraph 99 and refer to the Medicaid Act and its regulations for their provisions and terms.

33. Deny each and every allegation contained in paragraphs 100 and 101.

34. Deny each and every allegation contained in paragraphs 103 and 104, except admit the existence of 45 CFR § 246.10 (a)(3) and the State Plan and the New York Social Services Law and refer to their provisions, contents and terms.

35. Deny each and every allegation contained in paragraph 105, except admit that the Medical Advisory Committee had not met within the past year and was not consulted about the adoption or implementation of Parts 86 or 86-2 or the rates calculated thereunder, and refer to 45 CFR § 246.10 and the New York Social Services Law § 365-c(2) for their provisions and terms.

36. Deny each and every allegation contained in paragraph 106.

37. Deny each and every allegation contained in paragraphs 107 and 108, except admit the existence of the New York Administrative Procedure Act § 202.2(c) and refer to the specified statutory and administrative provisions for their terms.

38. Deny each and every allegation contained in paragraph 109.

39. Deny each and every allegation contained in paragraphs 111, 112 and 113, except admit the existence of Executive Law § 101-a and Administrative Procedure Act § 202.2(a), and refer to their provisions and terms.

40. Deny each and every allegation contained in paragraph 114.

41. Deny each and every allegation contained in paragraphs 117 and 118

42. Deny each and every allegation contained in paragraphs 120, 121 and 122, except admit the existence of Chapter 76 of the Laws of 1976, Parts 86 and its successor Part 86-2, that rates established pursuant thereto were for the period January 1, 1976 to December 31, 1976, and that defendants intend to recoup any amounts due from plaintiffs and other non-profit residential health care facilities as a result of adjustments in rates.

43. Deny each and every allegation contained in paragraph 123.

44. Deny each and every allegation contained in paragraph 125.

45. Deny each and very allegation contained in paragraphs 128, except admit the existence of 10 NYCRR § 86.16 in October, 1975, and refer to each word and to all of the terms and provisions of Part 86.

46. Deny each and every allegation contained in paragraphs 131, 132 and 133.

47. Deny each and every allegation contained in paragraphs 135, 136 and 137.

48. Deny each and every allegation contained in paragraphs 139, 140, 141 and 142.

FOR A FIRST COMPLETE AFFIRMATIVE DEFENSE TO THE COMPLAINT, DEFENDANTS ALLEGE:

49. This action is barred by the Eleventh Amendment to the Constitution of the United States.

FOR A SECOND COMPLETE AFFIRMATIVE
DEFENSE TO THE COMPLAINT, DEFENDANTS
ALLEGE:

50. The complaint fails to state a claim upon which relief can be granted.

FOR A THIRD COMPLETE AFFIRMATIVE
DEFENSE TO THE COMPLAINT, DEFENDANTS
ALLEGE:

51. The Court lacks jurisdiction over the subject matter.

FOR A FOURTH COMPLETE AFFIRMATIVE
DEFENSE TO THE COMPLAINT, DEFENDANTS
ALLEGE:

52. The plaintiffs, New York Association of Homes for Aging, Inc., and Hospital Association of New York State, Inc., which do not allegedly own or operate non-profit residential health care facilities, are not proper parties and have no standing to sue.

FOR A FIFTH COMPLETE AFFIRMATIVE
DEFENSE TO THE COMPLAINT, DEFENDANTS
ALLEGE:

53. Venue in the United States District Court for the Southern District of New York is improper.

FOR A SIXTH COMPLETE AFFIRMATIVE
DEFENSE TO THE COMPLAINT, DEFENDANTS
ALLEGE:

54. Plaintiffs have adequate remedies at law and in the Courts of the State of New York for judicial review of administrative determinations.

FOR A SEVENTH COMPLETE AFFIRMATIVE DEFENSE TO THE COMPLAINT, DEFENDANTS ALLEGE:

55. The rates and regulations of the Department of Health of the State of New York, Part 86 adopted on September 30, 1976 and its successor Part 86-2 adopted on November 29, 1976, were made and adopted pursuant to and in compliance with the New York Public Health Law of the State of New York, as amended by Chapter 76 of the Laws of 1976.

FOR AN EIGHTH COMPLETE AFFIRMATIVE DEFENSE TO THE COMPLAINT, DEFENDANTS ALLEGE:

56. Pursuant to the doctrine of abstention, this action should be dismissed pending determination and interpretation of the challenged rates and regulations by Courts of the State of New York.

WHEREFORE, the complaint should be dismissed with costs and disbursements.

Dated: New York, New York
January 20, 1977

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for Defendants
Office & P.O. Address
Two World Trade Center
New York, New York 10047
Tel. No. 488-4278
By

GEORGE C. MANTZOROS
Assistant Attorney General

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
--------------------------------------X

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., et al.,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al.,

Defendants.

--------------------------------------X

76 Civ. 5113
(TPG)

SECOND SUPPLEMENTAL AFFIDAVIT OF MITCHELL WAIFE

Served [illegible]
Received [illegible]
Entered in Docket [illegible]
Entered in Diary ___

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

MITCHELL WAIFE, being duly sworn, deposes and says:

1. I am a vice president of the New York Association of Homes for Aging, Inc. (NYAHA), and I submit this second supplemental affidavit in support of plaintiffs' motion for a preliminary injunction.

2. At the hearing before this Court on December 21, 1976, the defendants announced that, commencing January 1, 1977, residential health care facilities in New York would receive new Medicaid reimbursement rates which, in general, would represent increases of about 4 percent over the rates announced in November which are challenged in this lawsuit.

3. On the night of December 21, the new rates, to the extent they were available, were read to our attorneys over the telephone by representatives of the Department of Health in Albany.. Schedules listing the new rates were prepared that night and submitted to the Court (and marked

as Plaintiffs' Exhibits 15 and 16 for identification) on December 22, 1976.

4. At the hearing on December 22, the Court stated that the January 1, 1977 rates presented a new set of circumstances which, until analyzed, would preclude the granting of preliminary injunctive relief for any period beyond November and December, 1976 (i.e. those months during which the rates originally challenged would be in effect, assuming such rates are applied prospectively only). The Court directed the plaintiffs to analyze the January 1 rates and asked for and received assurances from the representatives of Department of Health that the Department would immediately undertake an objective review of the financial circumstances of those facilities most severely affected by rate reductions. (Transcript of December 22, 1976, pp. 124-130).

5. This affidavit is submitted to inform the Court that: (1) defendants' "review process" has amounted to a one-sided presentation by defendants of recommended budget cuts and has resulted in no relief being granted to any facility and (2) even assuming the actual implementation of the rates announced for January 1, in excess of 100 nonprofit facilities will still be receiving rates that are lower than their pre-November 1, 1976 rates and will still be facing the prospect of devastating reductions in services to patients or outright cessation of operations.

Defendants' Review Process Has Yet To Result In Any Relief Being Granted To Any Facility

6. On January 6, 1977, Dr. Cicero wrote to this Court (a copy of the letter is Exhibit A hereto*) advising that the review process promised on December 22nd had begun and that "Specific relief has been granted by this Department to three of the homes: Loretto Rest, Mary Manning Walsh and Hebrew Home at Riverdale." This sentence clearly sought to convey to the Court that any problems with these facilities had been resolved. However, as of our attorneys' last conversation with the office of the Budget Director on Friday, January 28, the stated new rates for these facilities had still not been approved. With respect to services rendered to Medicaid patients in December, Loretto, Walsh and Riverdale have been reimbursed at the November 1, 1976 rates which represent substantial reductions from their prior rates and which are wholly insufficient to meet operating costs.

7. Loretto, for example, is already three months behind in its mortgage payments to the State and is in default to many of its vendors. For services rendered to Medicaid patients in December, Loretto received reimbursement of $42.30 and $27.14 per patient day for its skilled nursing facility ("SNF") and health related facility ("HRF"), respectively. It did not even receive the $48 and $31.53 rates

---

* Because of their bulk, the documents referred to as "Exhibits hereto" will be submitted in a separate clasped booklet.

which Dr. Cicero told the Court on December 10, 1976 had been approved for that faility (Transcript of December 10, 1976, pp. 56-57), let alone the $55.90 and $39.51 rates announced in the letter of January 6, 1977. Given the inadequate December reimbursement, Loretto (a) is again unable to meet its next mortgage payment to the State, (b) is unable to make any payments to vendors, (c) by exhausting all of its available cash and obtaining an advance against its January reimbursement, will barely be able to meet its February 2, 1977 payroll, and (d) will be completely unable to meet its February 17, 1977 payroll. To make matters even worse, Loretto was reimbursed for November services at the pre-November 1 rates of $53 and $36 and, based on the Court's statement on December 22, 1976 that it was not prepared to grant an injunction covering November and December, Onondaga County Social Services* has advised Loretto that Loretto now owes the County the difference between the $53 and $36 rates it was actually paid for November and the $42.30 and $27.14 rates the Department of Health now claims it should have been paid for November, for a total of approximately $95,000. Loretto has been told that payment of this $95,000 retroactive amount -- which it simply does not have -- must be made by the middle of February and, until it is made, Loretto will receive no further Medicaid reimbursement.

---

* Medicaid reimbursement is administered by local offices of the Department of Social Services.

8. Even were the promises of higher rates made by Dr. Cicero in his January 6th letter belatedly to be carried out, it would only demonstrate the unfairness of allowing reimbursement at the inadequate reduced rates during the pendency of defendants' "review process" since, as in the cases of Loretto, Walsh and Riverdale, an indeterminate number of homes may ultimately be found entitled to far higher rates than they are now receiving.

9. With respect to the initial group of 13 non-profit facilities* referred to in Dr. Cicero's letter which were designated for expedited reviews, all have now met in Albany with representatives of the Department of Health. The "review process" for these homes has amounted to nothing more than the Department telling each of the homes that, no matter how reasonable its costs, it must make drastic budget cuts to live within its new, reduced rates. None of these homes had ever been previously told that any of its costs were excessive or that it should make any reductions in staff or programs. Indeed, several of the homes had only recently been told by the Department of Health that, in order to comply with State requirements, they must make increases in staff and programs. In any event, no relief has yet been granted to any facility and the review process promised on December 22 turns out to be no more than a duplication of the one-sided "management assessment reviews" held with respect to the named plaintiffs during the week

---

* The facilities in the first group, other than the named plaintiffs, are: Beth Abraham Hospital, Mary Manning Walsh Home Co., Inc., The Concord Nursing Home, Inc., Brookdale Hospital Center Nursing Home, Co., Inc., Jewish Guild for the Blind, Sephardic Home for the Aged, Lemberg Home & Geriatric Center, and Hebrew Home for the Aged at Riverdale.

of December 13 which the Court recognized "wasn't an objective adjudication of both sides of the controversy." (Transcript of December 22, 1976, p. 128) Simply telling facilities for the first time that they must immediately fire staff and reduce assistance to patients to live within the rate ceilings determined by defendants (the very rate ceilings which this lawsuit challenges as illegal) does not comport with what plaintiffs understood defendants to have promised the Court on December 22. Indeed, we do not believe that it comports with what the Court understood was being promised on December 22:

> "What I have in mind now is the Department will make a good-faith effort to hear both sides of the controversy and will come up with as objective an adjudication as possible of the problem." (Transcript of December 22, 1976, p. 128)

10. As shown in the written responses of the facilities which have already had their review sessions,* the cuts recommended by the Department of Health represent an attempt, not to make a fair assessment of a facility's reasonable costs or the needs of its patients, but to rationalize, on an ex post facto basis, the very rate ceilings challenged in this lawsuit. While certain of the proposed cuts can (and should) be made in areas not affecting patient care, were all of the cuts suggested by defendants actually to be implemented, the impact on patients would be

---

* The responses of Beth Abraham Hospital, Margaret Tietz Center for Nursing Care, Mohawk Valley, Sephardic Home for the Aged, Mary Manning Walsh and the Concord Nursing Home are, respectively, Exhibits B, C, D, E, F and G hereto.

devastating. For example, Beth Abraham Hospital Nursing Home, which had its review session on January 19, 1977, informed the Department of Health in its response dated January 21, 1977 that:

> "...the recommended cuts go far beyond any existing rules and regulations governing the operation of the institution, and would irreparably harm the functioning of this institution in its ability to meet patients' needs. Most significantly, however, it is our firm belief that were these cuts to be instituted at Beth Abraham Hospital there would be significant numbers of patient deaths directly attributable to these proposed staffing changes."
> (Exhibit B, pp. 1-2).

11. In the case of Mohawk Valley, the defendants recommended, among other things, that 20 of the 80 nursing positions be eliminated. Such a dramatic reduction in staff, Mohawk informed the Department in its response dated January 28, 1977:

> "...would reduce the level of patient care to the warehousing of human beings. We cannot, and will not, tolerate Nursing Home residents being forced to lay in their own urine and feces because nursing time is not available to promptly care for them. The decubiti caused by this neglect would require further nursing time leading to additional neglect. The multiple compounding of problems is obvious."
> (Exhibit D, p. 3)

12. Similar statements that implementation of the cuts recommended by the Department would have a grave impact on patient care were submitted by Margaret Tietz and the Sephardic Home. Margaret Tietz wrote:

> "Any reduction in staff rendering direct patient care would prevent the delivery of safe, humane and skilled care to our patient population.
>
> The proposed elimination of thirty-one full time equivalent positions of nursing staff would drastically diminish patient services."
> (Exhibit C, p. 3; see pp. 3-5 for specific details of the effects on patient care were the proposed cuts to be adopted.)

The Director of Nursing of the Sephardic Home wrote:

> "If I were to implement the substantial cuts in the Nursing Staff recommended by the Hearing Board, I feel the consequences of this act would be devastating to those whose lives have been entrusted to us. If our present standards of care are diluted by the State Board's cuts in personnel, I feel that chaos will be the final result."
> (Exhibit E, p. 1 of second attachment; see pp. 1-3 of second attachment for specific details of the effects on patient care were the proposed cuts to be adopted.)

See also the response of Beth Abraham, Exhibit B, pp. 4-11.

13. Since all of the homes in the plaintiff class are nonprofit - and virtually none have any reserves - the only alternative to making the cuts defendants would impose is to terminate operations. Exhibit H hereto is an affidavit of Edward Leone, Administrator of the Plaza Nursing Home in Syracuse, New York, which indicates that unless Plaza is able to obtain relief from its reduced rate, it will discontinue operations.* The Leone affidavit states that Plaza's projected costs per patient day for 1977

---

* Plaza was listed by plaintiffs in a letter to Dr. Cicero on January 3, 1977 as one of the homes requiring an expedited review. However, Plaza's review is not scheduled to take place until February 9, 1977.

are $53.44 and that "Plaza has never been told by anyone that its costs were excessive." (Exhibit H, para. 5) Plaza's pre-November 1 rate was $50.50, its November 1 rate was $43.42 and its scheduled rate for January 1, 1977 is $45.07 (Exhibit H, paras. 3 and 4). Mr. Leone states:

> "Being a not-for-profit corporation, Plaza has no reserves. At the present time our current cash payables greatly exceed our current cash receipts. We have no equity. Effectively, Plaza is bankrupt right now...Plaza cannot cut any service that it is now rendering without violating a code which, in turn, subjects Plaza to a $1,000.00 per day per violation penalty and a reduction in its rating."
> (Exhibit H, paras. 7 and 8)

Mr. Leone concludes:

> "The consensus of the Board of Directors of Plaza at the last meeting was that they would not continue to run a deficit. As I understand it, the Board of Directors will resign and return the facility to the New York State Department of Health to be run by it. It is extremely unlikely that it will continue Plaza. All the Medicaid patients (some 242 in Plaza) will be turned back to the Department of Social Services which is not equipped or ready for them (the Department doesn't have the beds or the facilities). The horrendous cost in human misery and human lives cannot be underestimated. The damages are irremediable."
> (Exhibit H, para 9).

14. Thus, whether a facility which has had its rate reduced implements the ill-conceived cuts defendants would impose or simply terminates its operation, it is the patients who will suffer and, in some instances, die. In this regard, I am advised by counsel that rate reductions resulting in the diminution of medical assistance to Medicaid patients may not, under federal regulations, be imposed by

the State or its agents until such patients have been given "timely and adequate" notice of the proposed reductions and an opportunity for a hearing. 45 C.F.R.§§205.10(a)(4)(i) and 205.10(a)(5). These regulations have not been complied with and, wholly apart from the other reasons advanced by plaintiffs, an injunction enjoining the implementation of reductions in the rates that existed prior to November 1, 1976 should issue, pending compliance by defendants with the required safeguards.

The January 1, 1977 Rates Do Not Affect the Need For a Preliminary Injunction

15. As directed by the Court on December 22, 1976, plaintiffs have analyzed the rates announced for January 1, 1977* and have determined that for more than 100 nonprofit facilities across the State, these rates, although representing a small numerical increase over the November 1, 1976 rates,** are still substantially lower than the pre-November rates and still leave these nonprofit homes with the choice of either making drastic cuts in the level of patient care or terminating operations.

16. Exhibit J hereto is a schedule prepared by plaintiffs listing each nonprofit facility (categorized under the headings "Skilled Nursing Facilities" and Health

---

* The January 1 rates have now been distributed by the Department of Health in the form of attachments to Hospital Memorandum Series 76-145, dated 12/30/76, a copy of which is Exhibit I hereto.

** Given the undisputed inflationary trends in nursing home operations, the small numerical increases reflected in the January rates will be more than offset by higher labor costs, etc. anticipated for 1977. The January 1 rates therefore really amount to no increase at all over the November 1 rates.

Related Facilities") which, after implementation of the January 1 rates,* will still be receiving less than it was receiving pre-November 1, 1976. As examples only, we set forth below the loss in income for 1977 that will be suffered by the five named plaintiffs under the January rates:

	Beds	Pre-November 1, 1976 rates	January 1, 1977 Rate	Loss in income for 1977
Cabrini	200 (SNF)	62.51	57.29	365,818
Margaret Tietz	120 (SNF)	71.26	53.20	886,933
	80 (HRF)	41.42	36.87	
Loretto	180 (SNF)	53.00	50.10	641,232
	400 (HRF)	36.00	32.73	
Mohawk Valley		49.32	44.62	197,626
Daughters of Sarah		50.92	46.93	314,659

Additional examples of the types of losses that will be suffered under the January rates are as follows:

	Beds	Pre-November 1, 1976 rates	January 1, 1977 Rate	Loss in income for 1977
Brookdale	220 (SNF)	76.75	62.28	1,115,463
Sephardic Home	129 (SNF)	60.18	50.59	696,661
	132 (HRF)	40.69	35.00	
Palisade	266 (SNF)	73.49	64.27	859,363
Beth Abraham	504 (SNF)	66.00	61.93	718,769
Plaza	242 (SNF)	49.52	45.07	377,346
Samaritan-Keep	196 (SNF)	45.55	38.24	585,658
	76 (HRF)	31.14	28.00	
Workman's Circle	259 (SNF)	51.30	45.52	531,816

---

*No facility has yet received any payment under the January 1 rates. Early in February, facilities will begin to bill for January services and payment at the January rates will not be received until late February or early March.

17. As the Court is aware, the pre-November 1, 1976 rates were the same rates that had been paid to virtually every facility in the State for 1975 and which were "frozen" for 1976. For the more than 100 nonprofit facilities listed on Exhibit J which will still be receiving less than their "frozen" 1975 rates even after the "increases" of January 1, 1977, the alternatives are to cut staff and programs (as defendants propose) or go out of business, in either case jeopardizing the health and lives of patients. As to these homes, the January rates have no impact on plaintiffs application for a preliminary injunction.

18. Accordingly, plaintiffs herewith renew their application for a preliminary injunction enjoining the implementation of any Medicaid reimbursement rates which are lower than the rates plaintiffs and the members of the class were receiving as of October 31, 1976. Although the grounds for the granting of the injunction have been set forth in previously submitted affidavits and memoranda, they are summarized here:

(a) Reimbursement rates which are lower than rates that were certified by the Commissioner of Health as "reasonably related to the costs of efficient production of [health care] service" (N.Y. Public Health Law §2807(3)) for 1975 cannot possibly provide reimbursement for such service on a "reasonable cost related basis" for 1977, as required by 42 U.S.C. §1396a(a)(13)(E), given the undisputed increases in the past two years in the cost of operating residential health care facilities. Thus, even apart from the undiputed procedural matters (e.g., failure to give 60 days notice of the reduced rates, failure to consult with the Medical Care Advisory Committee and failure to give notice and an opportunity for a hearing to patients whose medical assistance will be reduced), plaintffs have at least raised serious questions going to the merits of the issue whether any rates which are lower than the 1975 "frozen" rates comply with the requirement of the Medicaid Act that reimbursement be on a "reasonable cost related basis."

(b) Once serious questions going to the merits have been raised, the issue becomes whether the denial of the injunction will cause greater hardships than will the grant of the injunction. As shown above, if the injunction does not issue, those facilities which are to receive less money than they were receiving under the 1975 "frozen" rates will be compelled to make drastic reductions in patient care or cease operations. In either event, the health and, indeed, the lives of elderly recipients of Medicaid will be placed in jeopardy. Against the vital interests of these patients, the defendants desire to save money cannot amount to a sufficient counterweight. Moreover, if the requested injunction issues and defendants' ultimately succeed at trial, recoupment may be made of any monies found to have been wrongfully paid to any member of the class as a result of the injunction by deducting the amounts owed from subsequent reimbursement payments due the facilities involved. On the other hand, as defendants have argued, the Eleventh Amendment may be read as barring this Court from ordering retroactive recovery for plaintiffs so that if plaintiffs succeed on the merits, they may be left without a remedy for the wrongful losses sustained prior to trial absent the grant of preliminary injunctive relief. Thus, the balance of hardships tips decidedly towards plaintiffs.

19. Ten weeks have elapsed since plaintiffs first applied for a preliminary injunction. It is now clear that relief from the rate reductions precipitously imposed upon plaintiffs and the class will not be forthcoming from defendants. Plaintiffs, accordingly, must look to the Court. We ask that, for the reasons stated above, as well as those set forth in the papers previously submitted by plaintiffs, the motion for a preliminary injunction be granted at the earliest possible time.

MITCHELL WAIFE

Sworn to before me this
31st day of January, 1977

Jeffrey A. Mishkin
Notary Public

JEFFREY A. MISHKIN
NOTARY PUBLIC, State of New York
No. 31-4507312
Qualified in New York County
Commission Expires March 30, 1977

EXHIBITS TO THE
SECOND SUPPLEMENTAL AFFIDAVIT
OF
MITCHELL WAIFE
DATED JANUARY 31, 1977

EXHIBIT A

January 6, 1977

Honorable Thomas Griesa
Justice of United States District Court
Southern District of New York
United States Court House
Foley Square
New York, New York 10007

Dear Judge Griesa:

The New York Association of Homes for the Aging, by letter dated December 30, 1976, has submitted a partial list of its member facilities for our review in accordance with your directions. The Association subsequently asked us to add the Home for the Aged Blind. Acting on our own initiative, we have also added the Lemberg Home to the Association list of 12 facilities for a total of 13.

Enclosed please find our plan of action for reviewing the position of those residential health care facilities which claim to sustain significant losses. This plan has already been partially implemented. Our detailed review has begun.

Each facility has been asked to supply certain current information, so as to expedite the review process. I enclose copies of the 13 individual letters which have been transmitted.

Specific relief has been granted by this Department to three of the homes: Loretto Rest, Mary Manning Walsh and Hebrew Home at Riverdale.

For Loretto Rest, we recently computed new 1976 cost based rates of $48.13 for its nursing home, $31.54 for its health related facility, and $13.26 for its outpatient services. In addition, a partially completed patient assessment review will increase the rates to that of $55.90 and $39.51, respectively. The original rates were $42.30, $27.14, and $11.23.

BEST COPY AVAILABLE

The Walsh 1976 rate will be increased, on the basis of a new bed certification, from $53.48 in the nursing home to $65.55 and slightly decreased in the health related facility from $37.73 to $36.36.

The Riverdale 1976 rate, on the basis of an administrative grouping decision, will go from $48.72 to $60.67.

We are confident that our reviews can be completed within three weeks, on the assumption that the requested data is received from the facilities in a timely manner. You have my assurance that everything possible will be done to produce proper resolutions for every one of those facilities requiring relief.

Sincerely yours,

Frank T. Cicero, M.D.
Second Deputy Commissioner

cc: Mr. Nurick
Mr. Stern

Enclosures

EXHIBIT B

BETH
ABRAHAM
HOSPITAL

[illegible] Rehabilitation Center for the Chronically Ill
[illegible] at Bronx River Parkway, Bronx, N.Y. [illegible] • 920-6004

William H. Frohlich
Administrator

January 21, 1977

Mr. Donald Davidoff
Assistant Commissioner
New York State Department of Health
Empire State Plaza, Tower Building
Albany, N. Y. 12237

Dear Mr. Davidoff:

On two days notice Beth Abraham Hospital was summoned to a meeting in Albany on January 19, 1977 at 10:00 a.m. At the commencement of the meeting Beth Abraham was presented with a document prepared by the New York State Department of Health recommending proposed reductions in staffing at the institution which would, in the Department's opinion, allow Beth Abraham to function within code requirements and continue to receive the same ratings per service as they have had heretofore.

Beth Abraham Hospital was allowed 10 minutes in private to read, analyze and discuss the sixteen page document. Mr. Terry Friedland, counsel to the State Health Department, reconvened the meeting and began the proceedings. At no time had Beth Abraham Hospital been advised that it would either be required, or be to their benefit, to also be represented by legal counsel. The point was raised by Beth Abraham Hospital at the beginning of the meeting, to be included in the record.

It was explained by Mr. Friedland that a document would be prepared by the Health Department for submission to Judge Griesa following this meeting. The document would contain the Department's recommendations and the Department's own interpretation of Beth Abraham Hospital's response at this meeting to those recommendations. It was further indicated that Beth Abraham would have no opportunity to read or comment on the document prior to its being forwarded to Judge Griesa. Mr. Davidoff, upon joining our meeting for a brief period of time, stated that the institution could have until Tuesday to forward a written response to the items discussed in the meeting, to be included in the Department's response to Judge Griesa.

It is the institution's firm position that the recommendations made by the New York State Department of Health would cause the institution to subsequently relinquish any Very Good or Good State rating they currently enjoy in any department. It is further felt by the institution that the recommended cuts go far beyond any existing rules and regulations governing the operation of the institution, and would irreparably harm the functioning of this institution in its ability to meet patient's needs. Most significantly, however, it is our firm belief that were these cuts to be instituted at Beth Abraham Hospital there would be significant numbers of patient deaths directly attributable to these proposed staffing changes.

It is the recommendation of this institution that before staffing recommendations can be promulgated either increasing or decreasing the level of personnel, it is essential that base line data regarding the intensity of care being delivered at an institution be gathered, analyzed and appropriate allowance made for that intensity. It is Beth Abraham Hospital's contention that it is different from other nursing homes and that it functions as a chronic disease institution treating the subacutely and chronically ill patient. Because of the high intensity of service at the institution, much of the care delivered will reflect an appreciably higher cost than that delivered in an institution with the "average nursing home patient". This has not been taken into consideration in making the recommendations for cost reductions at Beth Abraham Hospital and, therefore, turns what might have been a constructive meeting into one of frustration and obvious inability to arrive at a solution to Beth Abraham Hospital's reimbursement problem.

The following charts, Nos. 1 - 2 - 3 - 4 will indicate succinctly why Beth Abraham Hospital is inappropriately grouped with nursing homes for purposes of reimbursement, and should be seen as uniquely a chronic disease institution.

CHART No. 1
An analysis of Chart No. 1 indicates the dramatic increase of chronically and subacutely ill patients admitted in each of the 5 years. While the increase over time is dramatic in all categories, special attention must be drawn to the total impact of the 1976 statistics which show a non-ambulant patient population of 72%. These are the patients who could not leave their beds if they were not physically lifted, carried and placed in wheelchairs. These are also the patients who must be fed through tubes inserted through their nasal passages to their stomachs, and those patients who are comatose, receiving oxygen either continuously or on an intermittent basis, patients with intravenous fluids continuously running, and patients who are incontinent of both their bowel and bladder due either to a medical cause or the surgical removal of an organ.

CHART No. 2
The analysis of Chart No. 2 is simple and dramatic. The patient population at Beth Abraham Hospital, which is circled on the right-hand side of the page for a 3 year period, should be compared to the line below titled "Total All Facilities". Once again, the conclusion is obvious. Beth Abraham's patient population is not ambulatory; 72% non-ambulatory compared to the total of all facilities which yields 25% non-ambulatory. 3% of Beth Abraham's patients are ambulatory, while 28% of the patients in the other institutions used to form our grouping of 300 bed and over facilities are ambulatory patients, most probably patients who can perform the activities of daily living for themselves.

CHART No. 3
Chart No. 3 indicates the length of stay of patients deceased or discharged in Beth Abraham Hospital in 1975 and 1976. One must note immediately that of the patients who died in Beth Abraham, 48% in 1975 and 46% in 1976 remained at the institution less than 3 months. This is a significant indicator of the severity of illness of the newly admitted Beth Abraham patient.

There was a significant increase in the number of discharges in 1976 as compared to 1975. Those 41% discharged patients during the first three months of their stay at Beth Abraham were discharged back to acute care institutions because of the severity of their illness. These are not patients who for the most part were discharged back to the community or other skilled nursing or health related facilities. The nature of the Beth Abraham patient makes it very difficult to place our patient in a skilled nursing or health related facility as they require an intensity of care that other facilities are not equipped to provide.

CHART No. 4
This chart illustrates the primary diagnosis of the patients at Beth Abraham at the end of 1976. One must bear in mind that even though this appears to be a wide range of diseases for which Beth Abraham is equipped to cope, each patient represents a multiplicity of diagnoses that is common among the chronically and subacutely ill.

It must be understood in the response that follows, that the foregoing discussion of the nature of the Beth Abraham Hospital patient, and the intensity of service required to adequately treat that individual runs concomitantly throughout each departmental analysis of the recommended reductions in staffing suggested by the New York State Department of Health.

Should you have any questions regarding any of the enclosed material please do not hesitate to contact me.

Sincerely yours,

William H. Frohlich
Administrator

WHF:ml

CHART 1

BETH
ABRAHAM
HOSPITAL

Medical Care and Rehabilitation Center for the Chronically I
Allerton Avenue at Bronx River Parkway, Bronx, N.Y. 10467 • 920-600

William H. Frohlich
Administrator

Beth Abraham Hospital has historically cared for the chronically and subacutely ill patient. The following chart expressed in a 5 year continuum, dramatically illustrates the multiplicity and severity of illness of patients admitted to Beth Abraham Hospital. This admission requiring a high intensity of service continues to increase to date, as the chart below expressed as a percent of our total population, shows.

	1972	1973	1974	1975	1976
Non Ambulant	62%	58%	72%	70%	72%
Semi Ambulant	32%	33%	19%	23%	24%
Require Wheelchairs	81%	79%	83%	90%	91%
Incontinent Bowel & Bladder	39%	56%	66%	74%	87%
No Verbal Communication	16%	15%	18%	16%	27%
Need Complete Help Eating	21%	22%	24%	32%	38%
Need Complete Help Dressing	50%	58%	59%	68%	75%
Nasogastric Feeding	1%	3%	6%	11%	13%
Comatose	1.6%	1.6%	2%	3%	3.5%

257

INSTITUTIONS BETH ABRAHAM HOSPITAL IS GROUPED WITH - INDICATING PATIENT AMBULATORY STATUS
DATA TAKEN FROM 1974 HE2V - HE2P

	AMBULATORY STATUS				AMBULATORY STATUS PERCENTAGE			
	Ambulatory	Semi-Ambu.	Non-Ambu.	Total	Ambulatory	Semi-Ambu.	Non-Ambu.	Total
Glendale Nursing Home	28	276	12	316	9%	87%	4%	100%
W.K. Nursing Home	92	113	109	314	29%	36%	35%	100%
DeWitt Nursing Home	220	179	97	496	44%	36%	20%	100%
Shoreview Nursing Home	76	45	189	310	25%	14%	61%	100%
Menorah Nursing Home	133	182	85	400	33%	46%	21%	100%
St. Ann's Nursing Home	135	213	2	350	39%	61%	0%	100%
Erie County Nursing Home	70	101	205	376	19%	27%	54%	100%
A. Holly Patterson Nursing Home	265	555	22	842	31%	66%	3%	100%
Ozanam Hall of Queens Nursing Home	107	114	96	317	34%	36%	30%	100%
Jewish Home & Hospital for the Aged	168	87	185	440	38%	20%	42%	100%
Jewish Institute for Geriatric Care	91	365	56	512	18%	71%	11%	100%
Eger Nursing Home	86	147	97	330	26%	45%	29%	100%
Ruth Taylor Geriatric Institute	120	184	7	311	39%	59%	2%	100%
Orange County Home and Infirmary	80	250	6	336	24%	74%	2%	100%
Beth Abraham - 1974	43	97	356	496	9%	19%	72%	100%
Beth Abraham - 1975	35	115	352	502	7%	23%	70%	100%
Beth Abraham - 1976	18	124	361	503	3%	25%	72%	100%
Total All Facilities 1974	1714	2908	1524	6146	28%	47%	25%	100%

Jan 14, 1977

BETH
ABRAHAM
HOSPITAL

Medical Care and Rehabilitation Center for the Chronically
[illegible] Avenue at Bronx River Parkway, Bronx, N.Y. 10467 • 920-6

William H. Frohlich
Administrator

LENGTH OF STAY OF PATIENTS DECEASED IN 1975 AND 1976

	DEATHS			
	1975		1976	
	No.	Pct.	No.	Pct.
Less than 1 month	52	26%	57	30%
1 month and less than 3 months	42	22%	30	16%
3 months and less than 6 months	22	11%	29	15%
6 months and less than 12 months	26	13%	22	11%
1 year and less than 2 years	22	11%	18	9%
2 years and less than 5 years	12	6%	15	8%
5 years and more	22	11%	21	11%
TOTALS	198	100%	192	100%

48%

LENGTH OF STAY OF PATIENTS DISCHARGED IN 1975 AND 1976

	DISCHARGES			
	1975		1976	
	No.	Pct.	No.	Pct.
Less than 1 month	16	18%	30	23%
1 month and less than 3 months	8	9%	24	18%
3 months and less than 6 months	11	12%	14	10%
6 months and less than 12 months	10	11%	16	12%
1 year and less than 2 years	9	10%	13	9%
2 years and less than 5 years	9	10%	16	10%
5 years and more	26	30%	25	18%
TOTALS	89	100%	138	100%

27%

BETH
ABRAHAM
HOSPITAL

Medical Care and Rehabilitation Center for the Chronically Ill
Allerton Avenue at Bronx River Parkway, Bronx, N.Y. 10467 • 920-6004

William H Frohlich
Administrator

PRIMARY DIAGNOSES AT BETH ABRAHAM HOSPITAL - 1976
(as of December 31, 1976)

		No.	Pct.
Nervous System		325	64.4%
Cerebrovascular thrombosis	122		
Paralysis agitans	37		
Multiple sclerosis	49		
Cerebral Palsy	21		
Chronic brain syndrome	20		
Hereditary and familial diseases	12		
Neoplasm	7		
Other	57		
Cardiovascular System		45	8.8%
Arteriosclerotic heart disease	28		
Arteriosclerosis generalized	3		
Myocardial infarction	7		
Rheumatic heart disease	3		
Other	4		
Musculoskeletal System		33	6.5%
Arthritis	23		
Paralysis, Post poliomyelitis	4		
Systematic Lupus erythematosus	3		
Other	3		
Endocrine System		24	5.0%
Diabetes Mellitus	24		
Digestive System		23	4.7%
Neoplasm	20		
Other	3		
Respiratory System		12	2.5%
Bronchial asthma	3		
Emphysema	2		
Chronic obstructive pulmonary disease	5		
Neoplasm	1		
Other	1		
Urogenital System		12	2.5%
Chronic renal disease	7		
Neoplasm	5		
Eye and Ear		3	.5%
Hemic and Lymphatic System		8	1.6%
Anemia	3		
Neoplasm	5		
Breast		9	1.7%
Neoplasm	9		
Skin		1	.1%
Scleroderma	1		
Fractures		9	1.7%
TOTALS		504	100.0

NURSING DEPARTMENT RECOMMENDATIONS

The Department of Health's recommendations that Beth Abraham Hospital can reduce its nursing staff by 7.7 supervisors, 30 nurses aides and orderlies, and convert 65.8 Registered Nurse positions to Licensed Practical Nurse positions must, of necessity, be viewed in its historical content.

In March 1975 Beth Abraham Hospital filed an appeal with the New York State Department of Health for an additional 63 Registered Nurses to be added to the institution's staff as recommended by the Health Department's surveyors commencing with their inspection of January and February 1975. While Beth Abraham had, for years, continuously requested additional nursing staff from the Health Department, it was not until this inspection that the surveyors finally examined the intensity of care needed to adequately deliver the appropriate level of care to the Beth Abraham patient population.

Using the standard Department of Health guidelines for the number of nursing hours required as it relates to intensity, the Department's surveyors recommended that Beth Abraham Hospital should increase its Registered Nursing Staff by 63 additional positions. An examination of the previous charts and attached exhibits "A" and "B" can only draw one to the obvious conclusion that the Beth Abraham patient population requires an even greater intensity of care today than it did in 1975. (Exhibit "B" contains the correspondence regarding this outstanding rate appeal)

There has been no action by the New York State Department of Health on this outstanding rate appeal No. 51828, while an examination of Exhibit "B" will indicate that Beth Abraham Hospital has lived up to its agreement.

The inconsistencies in the Department's recommendations in 1975 for additional Registered Nursing Staff and the January 1977 recommendations of significant decreases are totally inconsistent with their own positions and with the reality experience.

BETH
ABRAHAM
HOSPITAL

EFFECTS ON PATIENT CARE OF PROPOSED NURSING CUTS

The proposed reduction of 30 nurses aides and orderly positions, conversion of 65.8 Registered Nurse to Licensed Practical Nurse positions and the elimination of 7.7 supervisory positions would, if taken separately, result in severely diminished patient care services. Taken collectively, the following cause and effect would undoubtedly result if these ill conceived recommendations were to take effect:

Cause	Effect
I. Lack of sufficient staff to turn patients as frequently as medically ordered	A. Circulatory complications 1. Poor circulation 2. Skin breakdown (development of decubitis ulcers) 3. Edema B. Respiratory complications 1. Hypostatic pneumonia 2. Aspiration pneumonia 3. Dyspnea (difficulty in breathing) C. Contractures of upper and lower extremities (with loss of function) D. Pain and discomfort
II. Lack of sufficient staff to position patients as frequently as medically ordered	A. Muscle atrophy 1. Foot drop 2. Wrist drop B. Contractures of upper and lower extremities (with loss of function) C. Circulatory complications 1 . Poor circulation 2. Skin breakdown (decubiti) 3. Edema D. Respiratory complications 1. Hypostatic pneumonia 2. Aspiration pneumonia 3. Dyspnea (difficulty in breathing) E. Pain and discomfort
III. Lack of sufficient staff to change patients' soiled bed linen and clothing as frequently as required	A. Circulatory complications 1. Poor circulation 2. Skin breakdown (decubiti) a) Wet and soiled linen b) Wrinkled bedsheets c) Crumbs in bed 3. Edema B. Pain and discomfort C. Loss of dignity D. Unsanitary condition which increases microorganisms

EFFECTS ON PATIENT CARE OF PROPOSED NURSING CUTS (cont/d)

	Cause	Effect
IV.	Lack of sufficient staff to provide range of motion exercises for patients as medically indicated	A. Contractures of upper and lower extremities (with loss of function) B. Muscle atrophy of upper and lower extremities 1. Foot drop 2. Wrist drop C. Circulatory complications 1. Poor circulation 2. Edema D. Pain and discomfort
V.	Lack of sufficient staff to walk the semiambulant patient as medically ordered	A. Muscle atrophy with loss of functio B. Contractures of lower extremities C. Circulatory complications 1. Poor circulation 2. Edema of lower extremities D. Loss of dignity
VI.	Lack of sufficient staff to continue bowel and bladder retraining	A. Circulatory complications 1. Poor circulation 2. Skin breakdown (decubiti) B. Loss of dignity C. Discomfort
VII.	Lack of sufficient staff to lift and carry patient from bed to wheelchair	A. Circulatory complications 1. Poor circulation 2. Skin breakdown (decubiti) B. Respiratory complications 1. Pneumonia C. Contractures of upper and lower extremities with loss of function D. Muscle atrophy with loss of functio E. Discomfort F. Loss of dignity
VIII.	Lack of sufficient staff to provide for the forcing of fluids for patients who cannot or will not drink fluids voluntarily	A. Dehydration B. Electrolyte imbalance C. Elevated temperatures
IX.	Lack of sufficient staff to perform the patients' personal hygiene A.M. care Baths/Showers Shampoo Mouth care Nail cutting and cleaning Dressing & changing clothing as necessary Shaves	A. Unkempt, dirty and odiferous patien B. Mouth infections and diseases C. Skin conditions D. Scalp conditions E. Long, dirty toe and finger nails

EFFECTS ON PATIENT CARE OF PROPOSED NURSING CUTS (cont'd)

	Cause		Effect
X.	Lack of sufficient staff to collect specimens for laboratory or to collect urine specimens for lab-testing urines on diabetic patients	A.	A delay in giving insulin to diabetic patients
		B.	A delay in starting medications (i.e. antibiotics) which are medically ordered to begin after urine specimen is collected
XI.	Lack of sufficient staff to feed patients on a timely basis		
	1. Nasogastric tubes	1.	All feedings may not be given (i.e. some are ordered every 2-3 hrs
		2.	May be given faster than recommend with resulting vomiting & aspirati (due to lack of staff observation)
	2. Oral	1.	Meals will be delayed
		2.	Meals will be cold
		3.	Meals may run into one another
		4.	Patients will become frustrated at irregularity of meals and inabilit to keep appointments and may refus meals with resulting weight loss and possibly anemia
		5.	May violate code's recommendation re length of time between meals
		6.	Will alter time of certain medicat regimen (i.e. L-dopa, insulin)
XII.	Lack of sufficient personnel to apply devices such as: Braces Slings Hand rolls Footboards Prosthesis	1.	Contractures
		2.	Render patient immobile
		3.	Foot drop
		4.	Wrist drop
		5.	Increase in patient accidents
XIII.	Lack of personnel to record intake (fluids, intravenous) and output (urine, vomitus)	1.	Physician unable to get true medical picture, and so unable to write effective orders
		2.	Fluid imbalance
		3.	Dehydration
		4.	Fever
		5.	Pulmonary complications if on restricted fluids
		6.	Renal complications if on restricted fluids

EFFECTS ON PATIENT CARE OF PROPOSED NURSING CUTS (cont'd)

	Cause	Effect
XIV.	Lack of personnel to monitor vital signs: Temperature Pulse Respiration Blood Pressure	1. Physician unable to get true medical picture and so unable to write effective orders 2. Medications dependent upon vital signs cannot be carried out (i.e. medication for temperature, digitalis, hypotensive agent for elevated blood pressure)
XV.	Lack of staff to change decubiti and/or other dressings as ordered	1. Can result in infections 2. Patient condition worsening
XVI.	Lack of sufficient staff to observe:	
	a) Tracheostomies/suctioning	a) If not observed frequently, tube changed when necessary, and patient suctioned as needed, death may result
	b) Oxygen	b) May become life threatening if: 1. Not given to patient immediately when dyspnea occurs 2. If oxygen tank not changed before emptied
XVII.	Lack of staff would delay administration of medications/injections	1. Serious delays which may interfer with medical regime 2. "Skipping" a dose because time lapse between doses is not enough 3. Can seriously affect physical condition and well-being of the patient
XVIII.	Lack of staff would affect charting on medical record both on daily and monthly basis	1. Patients' conditions would not be observed and recorded promptly and accurately 2. Monthly nursing assessment of patients' condition and progress would be scant and incomplete
XIX.	Staff would be unable to make frequent rounds	1. Changes in patients' condition would not be detected early and so treatment would be delayed
XX.	Staff would have no time for interaction with relatives and patients	1. Would result in a sharp rise in patient and family complaints

EFFECTS ON PATIENT CARE OF PROPOSED NURSING CUTS (cont'd)

	Cause		Effect
XXI.	Lack of staff would result in a delay of executing doctors' orders	1.	This can be detrimental to patients and at times can be life threatening
XXII.	Lack of staff would result in poor observation of new admissions	1.	A poor nursing assessment of patients' condition would result

The items listed here do not constitute a total picture of how decreased staff would affect patient care. These are just some of the more obvious ways care would be affected.

BETH
ABRAHAM
HOSPITAL

EFFECTS OF CHANGING REGISTERED NURSES FOR LICENSED PRACTICAL NURSES

Due to the high level of skilled nursing care required by our very sick patient population, Beth Abraham Hospital finds it impossible to substitute LPN's for RN's for the following reasons:

1. The LPN can recognize simple problems and approaches only. Because our patients are comparable to an acute care setting, only the RN is equipped to ASSESS, PLAN, IMPLEMENT, AND EVALUATE the nursing needs of patients as mandated by the New York State Department of Health.

   Example - Patient has Foley catheter.

   LPN - might recognize that the urine is cloudy and chart it.

   RN - would make the decision to put patient on Intake & Output and force fluids.

2. The RN can make a nursing diagnosis. She writes and carries out nursing orders. The LPN is incapable of this.

3. Our patients have multiple diagnoses which makes nursing care more demanding and complex. The RN is best equipped to care for these patients.

4. The RN is able to understand and deal with the psychological aspects of long term care. She has depth of knowledge to treat the whole patient. The LPN does not.

5. The LPN is task oriented. The RN is person and individual oriented.

6. The LPN is unable to objectively supervise and discipline ancillary staff in her charge because of common Union affiliation. (67% of nursing staff is made up of ancillary personnel). She is subject to union pressure and discipline.

7. Most of our units function with one nurse on each tour. We have therefore forced this nurse to become:

   A. A ward clerk
   B. A unit manager
   C. A nurse clinician
   D. A supervisor
   E. A teacher.

   We expect her to:

   A. Assist with orientation of new personnel
   B. Identify nursing problems and assist with a solution
   C. Evaluate employees
   D. Counsel employees
   E. Evaluate nursing care
   F. Manage the unit efficiently and in an organized manner
   G. Do all clerical functions
   H. Deliver an adequate and safe level of nursing care to all patients
   I. Execute doctor's orders promptly.

   The LPN is not capable of performing this mammoth task.

8. To replace 65.8 RN's with LPN's would be contractually impossible since our registered nurses are represented by the State Nurses Association and the LPN's are represented by Local 1199 of the Drug & Hospital Employees Union.

9. The institution would have to re place the 65.8 RN's with a significantly larger number of LPN's in order to compensate for the LPN's lack of depth of knowledge. The cost would, therefore, be incremental.

The following excerpts are taken from a current pamphlet published by the National League for Nursing. They illustrate what the graduate from a practical nursing program is prepared to do as well as what the graduate with a diploma in nursing is prepared to do:

R.N.

> "After receiving a diploma in nursing, the graduate is prepared to plan for the care of patients with other members of the health team, to develop and carry out plans for the care of individuals or groups of patients, and to direct selected members of the nursing team. Successful completion of the state licensing examination permits the graduate to practice as a registered nurse (RN) in the state in which the license is issued. The diploma graduate in nursing has an understanding of the hospital climate and the community health resources necessary for the extended care of patients."

L.P.N.

> "After receiving a diploma or certificate in practical or vocational nursing the graduate is prepared to give direct patient care under the supervision of a registered nurse or a physician in simple nursing situations. In more complex situations, the practical (vocational) nurse functions as an assistant to the registered nurse. Successful completion of the state licensing examination permits the graduate to practice as a licensed practical or vocational nurse (LPN/LVN) in the state in which the license is issued."

The excerpt below was taken from the booklet "Assessing Health Care Needs in Skilled Nursing Facilities: Health Professional Perspectives" published by the U.S. Department of Health, Education and Welfare, March, 1976:

> "Nurses' assistants include practical or vocational nurses, nurses' aides, and nursing technicians. All have long been involved in providing direct nursing services to people in acute and long-term care settings, in peoples' homes, and in a wide variety of other community settings. Regrettably, those assistants too frequently have not had the supervision they need from competent professionals. Instead, they have been forced to act without their having the knowledge and skills essential to provide programs of good nursing care. Indeed, the laws governing institutional reimbursement for care of patients in skilled nursing facilities has encouraged the availability of only minimal and highly inadequate surveillance over such care by registered nurses."

THE NEW YORK STATE NURSES ASSOCIATION

Appropriate Functions of the Licensed Practical Nurse in Nursing Service

Published by

The New York State Nurses Association

Endorsed by

Hospital Association of New York State

Licensed Practical Nurses of New York, Inc.

New York State Department of Education

New York State Department of Health

This booklet is prepared as a guide to assist the members of nursing service in all health agencies to determine the extent to which duties may be assigned the licensed practical nurse.

The licensed practical nurse participates in the nursing care of patients within the scope of the legal definition. Article 139 of the State Education Law, Section 6901, Subdivision 2 (a) and (b) states: "The practice of nursing is defined as follows:

"(a) A person practices nursing as a registered professional nurse within the meaning of this article who for compensation or personal profit performs any professional service requiring the application of principles of nursing based on biological, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, and carrying out of treatments and medications as prescribed by a licensed physician or by a licensed dentist and the application of such nursing procedures as involves understanding of cause and effect in order to safeguard life and health of a patient and others.

"(b) A person practices nursing as a licensed practical nurse within the meaning of this article who for compensation or personal profit performs such duties as are required in the physical care of a patient and in carrying out of medical orders as prescribed by a licensed physician or by a licensed dentist requiring an understanding of nursing but not requiring the professional service as outlined in paragraph (a)."

It should be remembered that when duties and responsibilities are assigned to the licensed practical nurse for which he or she has not received preparation, the employer, the registered professional nurse who makes the assignment, and the individual licensed practical nurse can all be held liable for patient injury due to unsafe performance.

The legal responsibility of the licensed practical nurse is restricted to the performance of only those acts for which he or she has been prepared for the practice of practical nursing according to state law. The licensed practical nurse should accept only those assignments for which he or she has been prepared.

The licensed practical nurse gives direct patient care and functions as an integral part of the nursing team. The licensed practical nurse works independently in situations relatively free from complexity as a private practitioner in the home where she has a minimum of on-the-spot supervision from a professional nurse or the patient's physician. She also works with the registered professional nurse in more complex nursing situations, such as in hospitals or home health agencies.

The limitations of the licensed practical nurse's role are not so much in the nursing procedures which may or may not be performed, but in the individual situation and its requirement for safe nursing care. Whether a particular technique or procedure is within the sphere in which the licensed practical nurse may practice, or should be performed only by a registered professional nurse, depends upon the nature of judgment required to perform the procedure safely.

In each health agency, the responsibility for proper use of the licensed practical nurse rests with the registered professional nurse who assesses the nursing needs of patients and accordingly makes assignments, evaluates personnel competencies, and supervises activities. The registered professional nurse decides in which situations the licensed practical nurse can be permitted self-direction and in which the licensed practical nurse must work in a close relationship with the registered professional nurse.

The following considerations should be used in determining whether a particular practitioner will perform a procedure or function for a specific patient:

1. THE PATIENT'S

    a. condition
    b. type of assistive care and instruction required
    c. emotional and social needs

2. THE PRACTITIONER'S

    a. knowledge of the complexity of scientific principles underlying the procedure or function
    b. ability and skill acquired and demonstrated
    c. amount and character of supervision required to perform the procedure or function

Both the employing agency and the individual practitioner have a responsibility for the continuous development of knowledge and skills of each employee. On-going in-service education, based on individual needs, is one means of helping the licensed practical nurse perfect skills and keep abreast of changing trends in the practice of nursing. Each employee needs to be evaluated individually, since every person varies in the extent of abilities. The value of the licensed practical nurse as a member of the nursing team is determined by the extent to which contribution is made to the quality as well as the quantity of patient care. It is uneconomical to the agency, and frustrating to the licensed practical nurse, to withhold the nurse from performing those nursing functions which he or she is capable of performing.

A registered professional nurse has ultimate responsibility for nursing service, including the assignment of all nursing personnel. In situations which are complex, a registered professional nurse must be immediately available for direct care, when necessary, or for guidance and consultation.

The following material is to be used as a guide and does not attempt to give an all-inclusive list of procedures and functions for the licensed practical nurse. Each individual agency should, through a nursing practice committee or similar group, prepare its own list in line with its philosophy and objectives of nursing care.

UNDER DIRECTION, THE LICENSED PRACTICAL NURSE GIVES NURSING CARE IN SITUATIONS RELATIVELY FREE OF SCIENTIFIC COMPLEXITY

1. Function - Performing nursing procedures for which the preparation of the licensed practical nurse has provided the necessary degree of skill and judgment.

SUBFUNCTIONS	EXAMPLES
A. Assistance to the patient with activities of daily living and encouragement of appropriate self care	1. Assists patient as required in personal hygiene, grooming, comfort, rest and nourishment
	2. Assists patient with simple exercises as prescribed
B. Administration of treatments	1. Applies dressings to wounds other than those which open directly into a body cavity (i.e., open chest wound, T-Tube drainage, etc.)
	2. Irrigates functioning and regulated colostomies and catheters
	3. Inserts urethral catheters
	4. Administers oxygen
C. Preparation and care of patients receiving specialized treatments	1. Gives preoperative and postoperative care
	2. Assists physician with treatments, examinations, tests, etc.
D. Performance of special nursing techniques in caring for patients with communicable diseases	1. Maintains medical aseptic technique (i.e., gown, mask, gloves, etc., as indicated)

SUBFUNCTIONS	EXAMPLES
E. Administration of first-aid measures	1. Recognizes and takes immediate and appropriate steps to alleviate conditions of shock, respiratory failure, fainting, hemorrhage, etc.
	2. Takes immediate and appropriate steps to prevent further injury resulting from an accident
F. Administration of medications	1. Gives medications orally, subcutaneously, intramuscularly, by instillation, AND/OR
	a. which come in the unit dosage to be given and are properly labeled
	b. which are precalculated in the appropriate dosage system in use
	c. which are "p.r.n." to a patient whose condition is stable
	d. whose expected actions and reactions are known

II. Function - Observing, recording and reporting to the appropriate person.

SUBFUNCTIONS	EXAMPLES
A. Recognition of signs and symptoms indicative of changes in the general physical and mental condition of the patient	1. Observes and reports vital signs
	2. Observes and reports color or temperature changes in skin
	3. Observes and reports color and consistency of stool, urine and sputum
	4. Observes and reports restlessness and listlessness

SUBFUNCTIONS	EXAMPLES
B. Appreciation and recognition of stresses in human relationships between patient and patient's families, visitors and personnel	1. Observes depression or euphoria
	2. Observes irritation or anger
	3. Reports communication barriers

III. Function - Assisting with the rehabilitation of patients according to the patient care plan.

SUBFUNCTIONS	EXAMPLES
A. Awareness of and encouragement in the interests and special aptitudes of patients	1. Encourages use of hands in purposeful activities
	2. Encourages use of diversional activities
B. Encouragement of patients to help themselves within their own capabilities in performing activities of daily living	1. Encourages appropriate self care (i.e. combing hair, washing face, feeding self, etc.)
	2. Assists the patient with ambulation
C. Knowledge and application of the principles of prevention of deformities	1. Assists the patient with normal range of joint motion
	2. Applies principles of good body mechanics and body alignment
D. Utilization of community resources and facilities for continuing patient care	1. Knows community organizations and what services they render
	2. Has a basic knowledge of the need and mechanisms for referrals

IV. Function - Providing for the physical comfort and safety of patients.

SUBFUNCTIONS	EXAMPLES
A. Consideration of the needs of the patient for a safe, attractive and comfortable environment	1. Removes and/or reports accident hazards
	2. Regulates room temperature, ventilation and lighting
	3. Maintains a neat and clean environment

SUBFUNCTIONS	EXAMPLES
B. Preparation and after-care of equipment	1. Sterilizes equipment
	2. Observes aseptic techniques

V. Function - Assisting with the provision of emotional support of patients.

SUBFUNCTIONS	EXAMPLES
A. Understanding of human relationships between and among patients, families and personnel	1. Recognizes gross emotional and
	2. Understands general emotional needs and their possible effects on behavior
B. Recognition and understanding of the cultural backgrounds and spiritual needs	1. Respects religious beliefs of the individual patient
	2. Respects traditional patterns or mores of cultural groups
C. Recognition and understanding of the effects of social and economic problems upon patients	1. Is aware of the changing social scene and activities
	2. Recognizes the economic status of the patient and its effect on post-hospitalization planning and in-patient care
D. Protection of patients from behavior that would damage their self-esteem or relationship with families, other patients or personnel	1. Appreciates the need for warmth and tact
	2. Appreciates the need for both security and independence
	3. Respects the confidentiality of patient's affairs

VI. Function - Promoting effectiveness of the employing health service agency.

SUBFUNCTIONS	EXAMPLES
A. Participation in the development, revision, and implementation of policies designed to insure safety and comfort of patients and personnel	1. Participates on committees
	2. Contributes to team conferences
	3. Actively participates in safety programs

SUBFUNCTIONS	EXAMPLES
B. Promotion of cooperative effort through understanding the functions of all personnel involved in patient care	1. Knows job descriptions of all levels of agency personnel. 2. Knows channels of authority and lines of communication
C. Utilization of community relationships for better understanding by the public of health services	1. Is a member and serves on committees of community organizations 2. Is active in community projects
D. Utilization of opportunities in contacts with patient's relatives to promote better understanding of the health service	1. Is available during visiting hours to answer or refer questions 2. Reinforces the patient and family teaching program 3. Utilizes opportunities to promote good public relations

IN MORE COMPLEX SITUATIONS THE LICENSED PRACTICAL NURSE FUNCTIONS AS AN ASSISTANT TO THE REGISTERED PROFESSIONAL NURSE

I. Function - Works in specialized care units under the immediate direction and supervision of the registered professional nurse.

EXAMPLES

1. Assists with tracheostomy care and suctioning
2. Assists with intermittent positive pressure breathing
3. Assists with thermal therapy
4. Assists with immunizations and tests

II. Function - Participates in the planning and evaluation of nursing care under the guidance of the registered professional nurse.

EXAMPLES

1. Participates in team conferences
2. Reports effects of treatments

Recommendations by E. Wienick, Nurse Surveyor N.Y.S. Dept. of Health re: Reductions in Nursing Supervisors

It is not possible to reduce our supervisory staff for the following reasons:

1. Most of our units operate with one nurse. As stated previously her job is overwhelming to say the least. A supervisor must be available to assist and guide her in completing her duties.

2. Since we have only one person in Inservice Education, the supervisors have responsibilities in teaching personnel.

3. Nurses need much support and guidance in counselling and disciplining employees. Supervisors work closely with staff in this area.

4. Supervisors are responsible for evaluating and improving nursing care.

5. They identify and solve, where possible, nursing problems.

6. Supervisory staff spends much time assisting staff in completing necessary Medicaid and Medicare forms ie DMS-1, 418, etc.

7. Because nursing homes generally do Not attract the highest calibre of nurses and because our patients require a high level of skilled nursing care much time is consumed in their being available to guide, direct and act as a resource person to the floor nurse.

8. Because of the high level of nursing care required and the complex problems that frequently arise in these patients, the supervisors can only be responsible for a limited number of nursing units, of which we have 14.

9. Because our patients require active medical treatment and their medical orders change frequently the supervisor must be available to direct and/or assist the nurse in executing these orders promptly.

10. Supervisors are active in assisting nursing staff in formulating and revising the ever changing plan of care.

11. Because of limited floor staff, time to devote to patient problems and relative's complaints is handled by the supervisor.

12. The supervising nurse is often called upon to act as buffer between floor nurse and doctor when they meet an impasse. This is usually due to pressures and tensions created by an abnormally heavy workload. The Supervisor also is often the sounding board

Recommendations by E. Wienick, Nurse Surveyor
re: Reductions in Nursing Supervisors Cont'd

not only for physicians but other departments as well (re patients late for clinic appointments, etc.)

13. The Supervisor develops, reviews and revises nursing care procedures and policies and interpets same to staff personnel.

14. The supervisors represent the Nursing Department and takes an active role in intradepartmental meetings such as safety, relatives, and those necessary for planning patient social functions.

Re: Aides and Orderly Reductions

At the meeting on 1/19/77 in Albany, the New York State Department of Health consultant, Edna Wienick, recommended Beth Abraham Hospital cut 30 nursing aides. She stated that on:

7-3 tour of duty, 1 aide per 8 patients is recommended
3-11 tour of duty, 1 aide per 9 patients is recommended
11- 7 tour of duty, 1 aide per 10 patients is recommended

Ms. Wienick further stated that in order to cover for vacations, holidays, etc. 1.4 people are needed to cover each person on a yearly basis.

On December 16, 1976 the Directors of Nursing affiliated with the Central Bureau for the Jewish Aged met with the New York State Department of Health consultants. At this meeting we were told by Ms. Lillian Kaplan that 1.6 people are needed to cover each person on a yearly basis. Ms. Wienick was present at this meeting as the minutes indicate. I refer you to the bottom of Page 1 and top of Page 2 of the minutes - Nursing Care Hour Requirements and Their Computation. Using their calculations which to date have not changed as confirmed by Dr. Michelin at the 1/19/77 meeting, we would need:

7-3 tour 1 aide: 8 patients = 5 aides for 37 pts.x14 units = 70
3-11 tour 1 aide: 9 patients = 4 aides for 37 pts.x14 units = 56
11- 7 tour 1 aide:10 patients = 3 aides for 37 pts.x14 units = 42
168 aides needed on duty daily

168 aides needed daily
x 1.6
1 008
1 68
268.8 aides needed on staff

We currently have 228 ancillary personnel on staff. Following this reasoning to its obvious conclusion, we would need to add an additional 40.8 aides.

Even if we were to use the incorrect figure of 1.4 we would need to add an additional 7.2 aides. See next page.

278

Re: Aides and Orderly Reductions...... cont'd.

```
   168 aides needed daily
X  1.4
   672
  168
  235.2
```

Central Bureau for the Jewish Aged
Joint Meeting
Committee of Directors of Nursing
and
Nursing Services Consultants, New York State Department of Health, Division of Hospital Affairs
Minutes - December 15, 1976

Present: CBJA Nursing Directors
Sonya Hirschberg, Chairperson; Marjorie Barnave, Nettie Cohen, Anastasia Cunningham, Sara Diamondstein, Gladys Dow, A. Fisher, Janet Freeman, S. Gooding, Theresa Hirschberg, Myra Harrison, Emily Kass, Louise Macchia, Juanita Meredith, Josephine Mittelmark, Mary Ann Morelli, Myra Peskowitz, Marjorie Sears, Eleanore C. Smith, Clara White, Hilda Wolf, John Karpeles and Mrs. Ruth Esterowitz.

N.Y.State Dept. of Health
J. Warren Toff, M.D., Anne Lee, R.N., Lillian Kaplen, R.N., Edna S. Weinick, R.N., Juanita Civello, Marianne Fogarty, Geraldine Laport, Marianne Carrera
and the Nursing Services Consultants, New York State Dept. of Health.

Purpose of the joint meeting was to clarify certain areas of confusion between Directors of Nursing and NYS Dept. of Health Nursing Services Consultants.

Sonya Hirschberg, Chairperson of the CBJA Nursing Directors Committee pointed out in her preliminary remarks that despite the State's contention that "paper work is not as important as good patient care" the fact is that the paper work is tied into the reimbursement rate. This is of great concern to the administrators as well as to the Nursing Departments. Specifically, Nursing Directors wanted to address themselves to:

a) a clarification of patient plan of care and the contradictions between HEW and State requirements; also how the requirements differ in the HRF areas,
b) clarification of the basis of computing "nursing homes" both for HRF and SNF; has 4,2,1 formula been dropped from code and how will it be interpreted?
c) interpretation of "restorative and rehabilitative" nursing,
d) priorities of care vis-a-vis the fiscal crisis. What do the consultants consider to be their priorities and how do they view use of staff for non-patient care work in view of the Nursing Department's responsibility for documentation for the state and fiscal intermediaries.

I. Nursing Care Hour Requirements and their Computation

State Health Department evaluates capability and is aware that compliance impedes capability. The State, therefore, has been in the process of revising the Code.

HEW is developing a survey instrument which will be patient centered, not facility centered.

Regarding computation of nursing care hours: multiply the time sheet entries by seven for the total nursing care hours and divide by number of patients to get the number of care hours given per day (you need 1.6 people to cover on an annual basis) guidelines allocate 1/2 to 3/4 patient care hours per day so the recommendation made by consultant staff is not to admit residents who need more than that amount of care. It was felt also that HRF's are staffed too high and SNF's too low.

II. Priorities of Care

Greatest problem appears to be one of communication - "What do you mean" as opposed to "what do I mean?"

The assessment process is the most difficult and requires the most skills, and to that end, good baseline data is crucial.

Setting of priorities: The most important considerations are the patients needs and their complexities which can be determined by observing and then evaluating the patients.

The RN should be the one setting the priorities, receiving the pertinent baseline data to be able to make an assessment. Collaboration with other disciplines is most essential.

The State does not place documentation before assessment (which is on an unending continuum requiring continuous reassessment).

Director of Nursing is responsible for educating her staff, developing their skills and meeting problems of patient care. She has to have skills in sorting out pertinent information so that the process focuses on the patient.

Criteria for admitting a patient to SNF are based on nursing needs of the patient. Nurses are responsible for and held accountable for patients.

III. Patient Care Plan - HEW and New York State Requirements

Federal and State regulations provide for a patient care plan (CPP) which is multidisciplinary and comprehensive. There are no federal government guidelines, however, as to what they want in a PCP. There is much "see sawing between no paper work and excessive paper work. Consultants realize the need for standardization and have had meetings with HEW regarding their expectations and interpretations using nursing feedback to bolster their position.

The HEW Regional Office developed a mechanism for compliance which appears to be more appropriate for a 500 bed facility. It contained a component by which the State could judge the kind of care rendered. The rationale for so much reliance on paper work is that it is needed to judge what has been happening over a period of months; it is used as a mode of communication between disciplines within the facility.

There are no specific forms to document PCP and each facility can devise its own. What is needed, however, is evidence of planning either by progress notes or using any other device. At the present time, at least, you need an annual review in SNF. Where a patient displays frequent changes, a more frequent PCP is needed. For the Resident Care Plan in an HRF the federal requirements are a quarterly review which has to be documented. You don't need a total reassessment.

The Nursing Component in the PCP requires:

a) a realistic long-term goal and a realistic short-term goal: In an SNF, for example, the long-term goal might be restoration to continence over a period of a few months and the short-term goal would be to initiate a bowel and bladder training program.

b) The RN formulates the goals and the aides are to carry them out. The goals should include the patient's nursing needs, the disease components involved in his care, the patient's personal habits so that anybody picking up the record would be able to handle the patient (i.e. where the patient's cup is placed on the tray.)

c) State code requires a revision of PCP every 30 days and a revision for medication. Also required is a quarterly review, not necessarily in-depth, unless there are big changes taking place.

d) The PCP can be kept on a cardex or any other convenient format.

e) In an HRF, the Resident Care Plan can be made in the record or any form used by the facility. A suggestion was made to reduce duplication of records.

f) Rehabilitative needs in PCP include ambulation, turning schedules, bowel and bladder training and other specific, individual needs. (Do not include brushing teeth or bathing in the PCP.)

g) You need a policy on how you are going to formulate the PCP (for example, by meetings or a written policy you have to indicate how you expect to arrive at a total PCP and who will be responsible for each component). The State cautions that there will be deficiencies for not following your own policy.

IV. Restorative and Rehabilitation Care

Surveyors do see what's going on with regard to patient care despite the appearances to the contrary. They observe the interaction between staff and patients; the amount of communication during the reality-orientation program, the appearance of patients - grooming, clothing, cleanliness, haircuts; the availability of rails in the halls, bathrooms, the amount of ambulation given to patients requiring it, the body allignment of bedridden patients; beauty shop and barber shop facilities; degree of communication between the various disciplines; the maintenance program within the PCP, etc. etc.

The questions raised were what is the basic policy with regard to rehabilitation and restorative nursing? How do you follow it? Is it realistic? What are the procedures for ambulatory patients? What is documented in in-service training programs re. restorative and rehabilitative nursing? How and what are nurses documenting in the PCP and nursing notes which reflect that rehabilative nursing is part of the patient's daily care?

V. Rating System

How are surveyors evaluating care in light of the fact that it is tied to the reimbursement rate? The three part answer includes:

a) Structure - what tools you use, i.e., text books, policy and procedure manuals.
b) Process - what you do on an ongoing basis to implement structure.
c) Outcome - realistic results emanating from the realistic goals which were set.

The issue raised was that each department expects or wants a very good rating. In order to achieve that, innovative but realistic programs have to be developed in cooperation or in conjunction with other disciplines. For example, the legal requirement that there be a UR plan should be used to help the Nursing Department in the areas of patient care and the evaluation of a PCP. Cited examples of "innovative programs were:

a) a medical study, such as use of drugs.
b) planned programs of supervision with different sets of patients.
c) establishing criteria and standards for specific approaches to nursing.
d) program in cooperation with psychiatrists.

All these require documentation by using behaviorally-directed notes - what you did and what were its effects? Nursing has to document their notes with regard to specific results. Nurses also need to document the effects of policies of other disciplines. This is the time, it seems, to experiment and test out some of your pet theories in the area of patient care.

Since you need a policy manual at the present time you can try to document a study regarding the possibility that you don't need it.

Regarding "creative leadership" a study prototype was cited one half of the supervisors using one procedure for catherization and the other half using another. If it is written up, it can be used as evidence of innovation.

Since government studies indicate that doubling staff doesn't improve patient care, the goal should be for upgrading one's staff rather than increasing it.

Nursing Department will be rated with every survey. Outcome will be the most important part of the new rating chart. Nursing Directors were asked for greater input in the direction of innovative programming.

Questions and Discussion

1. Regarding use of restraints, wheelchairs with safety belts are not considered restraints but are considered to be safety devices.

2. Nurse practitioners or physician's assistants cannot do physical assessments. The physical assessments must have an M.D. countersignature.

3. The DMS-I has to be initiated in an acute care hospital by the on-site nurses (Call Mr. Korelenks if there are any problems) Nursing Consultants have no responsibility in this area. Writing to Dr. Toff about this issue might help clarify it.

4. Other disciplines are requesting to attend the nurses in-service programs, which may meet the needs of the staff to a greater degree than the needs of the patient. There is some confusion in this area since other departments were penalized for not participating in in-service training programs. (Dr. Michalin should be involved in clarifying this with regard to other disciplines.) Certain areas such as fire-safety (Engineer's concern), Bill of Rights (Social Service's concern) are mandated in the code and coverage should be provided for the entire staff. Certain staff, such as P.T. or O.T. can be incorporated in the nursing in-service training programs which might be given twice a year. The degree of participation in point programming is an administrative decision.

5. There is no specific definition of restorative and for rehabilitative nursing care. Interpretation of this concept is, therefore, quite loose. In general, rehabilitation is an activity to restore function and it is hoped that all nursing is, to some degree, rehabilitative. Regulations re rehabilitative nursing indicate that it has to be documented in orientation and in-service training sessions and reflected in the nurses' plans.

6. There are no minimum nursing care hours required by law. State will accept evidence that some patients require 6 or 8 hours of nursing care.

7. Language barriers between patients and staff continue to be a problem in good communication. Use of family, Social Service Staff and sign language may improve situation. Programs trying to teach staff another language are being removed because of fiscal crisis.

8. State Department of Health will accept as evidence of in-service training a short daily entry indicating a staff meeting, a floor meeting, a case conference, etc. It does not have to be an elaborate report on a patient conference. A program under some supervision is not necessarily in-service. Supervisors should be brought to the unit or the floor, not vice versa. It was recommended that we use advantageously what we're doing and give it a "label."

9. Innovative programs have to be planned, not big. Small pilot projects are acceptable under the characterization of innovative programming.

10. Since the Department is being rated on every survey, it is hoped that this rating will shake down to "acceptable" or "not acceptable" instead of the more complicated system in current use.

EFFECTS OF DECREASED STAFF ON REMAINING STAFF:

1. Sharp increase in medication errors

2. Sharp increase in absenteeism

3. Staff turnover due to:
   a. increased duties
   b. heaviness of units
   c. lack of job satisfaction

4. Low staff morale

5. Increase in employee incidents

6. Increased harrassment by patient and relative complaints

7. Decreased initiative and incentive

All these factors will produce an unresponsive, uncaring staff and create insensitivity to patients' needs, thereby decreasing productivity and lowering Beth Abraham Hospital's high nursing standards, which if anything have to be raised to even higher levels.

MEDICAL

The Medical reimbursement ceiling is inappropriate as it fails to take into consideration the intensity of care required by the chronically ill and the subacute patients at Beth Abraham Hospital, almost half of whom belong in acute hospitals. The nature of the Beth Abraham patient population has been well documented by the New York State Department of Health surveyors and is included for reference in this appeal as Exhibit A. The Medical reimbursement structure is geared to the needs of a nursing home whose patients do not require intensive services such as the patients at Beth Abraham.

"The complexity and overall severity of the major illnesses with which patients are referred to Beth Abraham Hospital such as;

a. Amyotrophic lateral sclerosis
b. Multiple sclerosis
c. Adeno carcinoma with metastasis
d. Spastic quadriplegia
e. Coma vigil
f. Bilateral cerebral vascular occlusions
g. Encephalitis
h. Dystonia musculorum deformans

justify a considerable amount of time and effort on the part of all professionals in maintaining these patients at an optimal level of function. The complementary character of medical care dictates that good medical care be supported by good nursing care. Gross generalizations and simplistic suggestions relating to reducing the delivery of medical care to a bare minimum would lead to an increasing frequency of patient morbidity and mortality. It would also thoroughly destroy medical services currently provided and have a major adverse effect on the ability of residual caretakers to provide even marginal health care within the Federal and State regulations. It would be a morally corrupt decision without justification."

Dr. Harvey Shapiro, Medical Director
Beth Abraham Hospital

The New York State Department of Health surveyors themselves attested to the level of care provided at Beth Abraham Hospital in their recommendation that the registered nursing staff be increased by 63 positions. (See Exhibit B) A registered nurse cannot function alone; she needs direction and guidance which can only come from a physician. One must question, following that recommendation, whether Beth Abraham requires additional physicians, not less. The following analysis must inevitably draw you to that conclusion:

The Medical Department is supervised by 1 full time Medical Director who is responsible for the overall planning, organizing, coordinating and directing of that department. There are 9 house physicians at Beth Abraham

MEDICAL CONTD.

Hospital. Each physician has a panel of approximately 63 patients since the total of one physician's time is used for 24 hour on site coverage. There are 2 full time attending physicians, each of whom is responsible for the medical activities of 252 patients. Each attending physician directly supervises the activities of 4 house physicians. House physicians at Beth Abraham Hospital perform the typical 40 hour work week, plus night and weekend coverage on an every 8th night schedule, contributing to an average work week of 57 hours per house staff physician. It is Beth Abraham Hospital's policy that a physician following night or weekend coverage is not given the following day off, but works that day as a regular scheduled days work.

The number of physicians necessary is further dictated by the severity of patient illness. Appended to this analysis are the admissions for two months in 1975. Your attention is drawn to the multiplicity and severity of problems the vast majority of these patients represent. It should be remembered that Beth Abraham admitted 293 patients in 1975 and 330 in 1976 of which the attached 45 admissions is just a typical fraction thereof. (See Exhibit "A" No. 8)

Much of the physician's time is spent directly with the patients. However, an inordinate amount of his time is mandated to be spent performing record keeping functions in order to comply with code requirements. The following is a listing of the various time consuming tasks that Beth Abraham's house physicians are required to perform:

Comprehensive history and detailed physical examination

The severity and complexity of illness at Beth Abraham Hospital necessitates frequent medical intervention for prophylactic, diagnostic and progress evaluation.

Innumerable medical emergencies requiring comprehensive diagnostic workup and therapy.

Documentation of all medical evaluations.

Clinical rounds with the attending physicians and with the nurse.

Due to the severity of illness, a substantial number of laboratory and x-ray request forms must be completed by the physician.

Medical orders must be written appropriately for each patient and general orders must be rewritten on every patient at a minimum of monthly intervals.

Consultation reports must be completed in detail and an appropriate followup is required.

MEDICAL CONT'D.

Frequency of patient incidents and detailed completion of incident reports.

Severity of patient illness also requires a high frequency of blood drawing, starting and restarting intravenous lines, nasogastric intubation, foley tube insertion, electrocardiograms, paracentesis, thoracentesis, etc.

Physician time is required for completion of various forms such as social security forms, physicians care plan and interdisciplinary care plan, responses to utilization review procedures dealing with possible errors of omission or commission.

Transfer papers for intrahospital utilization in the event of an acute medical or surgical problem requiring intensive monitoring or therapy.

Completion of recreation, physical therapy, occupational therapy, dietary and social service forms required on admission and periodically.

Due to the instability and unpredictability of patient clinical status, high frequency of phone calls from relatives in regard to patients' welfare.

Physicians meet personally with relatives throughout the day to discuss their current status.

In the event of any sudden change in patient status, which occurs with high frequency, phone calls must be made notifying the family.

Regularly scheduled pre-admission meetings with social service in discussing the newly anticipated patient.

Periodic meetings between the physicians and the social service worker assigned to the floor dealing with the overall problem regarding patients welfare.

ADMINISTRATION

The Health Department recommendations that the administrative component be reduced by one-third and that salary levels be significantly reduced for the remaining administrative staff, were not substantiated at the meeting with any concrete examples of why the current staffing was not in line with industry norms, which Beth Abraham Hospital feels it is, nor why the salary structure was also out of line with industry norms, which Beth Abraham Hospital feels it is. It is necessary to have an administrative structure as Beth Abraham does, to maintain the levels of care provided at this institution and administer the large numbers of complex departments providing the highly intensive care at the institution. It must be remembered that we are, once again, dealing with a chronic disease institution and not the average skilled nursing facility.

Historically, the admitting function at Beth Abraham has been performed by the Social Service Department through the employ of individuals with a Master's in social work degree and case aides. The intake procedure is one of heavy patient and family involvement due to the nature of the chronically ill patients admitted to Beth Abraham. This is a function which can best be performed by trained social workers in our setting. The social workers visit the homes and institutions where the patients reside prior to placement in this long term care setting and are required to develop a medical, social assessment only a trained social worker can provide. Therefore, the admitting costs should appropriately be charged to the Social Service Department and are inappropriately lumped under the administrative category.

The elimination of the Personnel Department, with the exception of one position, is inappropriate in the Beth Abraham Hospital setting. The Personnel Department is manned by trained individuals who deal on a daily basis with the contract interpretations for both 1199 of the Drug and Hospital Employees Union and the State Nurses' Association which represents the R.N's. In addition to those complex tasks of interpretation, the department is responsible for the complex grievance procedures required by both union contracts, and represents the institution at labor arbitration hearings. At the present time there are 6 labor arbitrations that Beth Abraham Hospital is currently involved with.

In addition to these functions the Personnel Department must maintain adequate employee records for all regulatory agencies and maintain the benefit program in all of its complexity for the total institution. To recommend, as the Health Department has, that this department can be eliminated with the exception of one position which reports to an Assistant Administrator, which they are saying at the same time be eliminated, runs counter to logical thinking. The resulting increases in costs due to inadequate record keeping, grievance handling and the employment function for the total institution would dramatically increase the costs to Beth Abraham Hospital, and in our opinion negate any conceivable savings that would be made.

HOUSEKEEPING

The Health Department's calculation of 95 full time equivalent employees now in the Housekeeping Department is fallacious. The Department used a figure for the number of hours worked in the department for 1974 and divided that by full time equivalence. As a result, the Health Department mistakenly believes there are 95 people in the Housekeeping Department of Beth Abraham Hospital. In actuality, Beth Abraham is operating the Housekeeping Department with 52 employees which is barely enough to cover for sick, vacation, holiday and other scheduled time off. The recommendations by the New York State Department of Health were that Beth Abraham can meet its housekeeping requirements with a total staffing of 33 people in the department, including all supervisory and department head employees.

There are 7 elevators at Beth Abraham which patients cannot use unless there are elevator operators to run them. Our patients are non-physically able to operate the elevators, nor would they be physically capable of calling for help should there be a break-down while they are riding in one. In order to operate the 7 elevators for the 12 hour time span that they are required to be run, the institution must have a minimum of 10 elevator operators. When asked whether the elevator operators were to be considered part of the 33 employee figure recommended by the Department, we were told - yes they were, the 33 figure was to include everybody. The figure of 33 employees to staff the Housekeeping Department and elevator service with for a 504 bed institution such as ours, with the intensively ill patient, is an inappropriate suggestion and cannot be entertained without additional information and justification, and staffing patterns.

80% of the employees in the Housekeeping Department receive four weeks vacation per year because of their length of employment and mandated by union contracts imposed upon us by State mediators and arbitrators. It must be recognized that there are 14 patient floors to be cleaned daily, 3 basement areas, and 4 floors of ancillary services. The entire complex consists of 3 buildings each of which is a block long.

Using the days per year per employee criteria established by the Health Departme in evaluating nursing staffing, it must be noted that out of a possible 73 shif per year that must be covered in any one position, 40 shifts are generally worke by an individual employee leaving 33 shifts to be covered with relief personnel due to the aforementioned 4 week vacation time, 12 days sick time per annum, disability and 12 holidays per annum.

Included as Exhibit "C" is the housekeeping staffing requirements for Beth Abraham using the resource monitoring system. An examination of this in depth analysis of the housekeeping staffing requirements, indicates the need for a total of 60 positions in the housekeeping department which does not include the additional 10 elevator operators that are required by the institution, thus bringing the minimum staffing requirements to a total of 70 positions needed in the Housekeeping Department.

LAUNDRY

The recommendation that the laundry reduce its personnel by 3.1 full time equivalent is an inappropriate and counter-productive recommendation. The laundry at Beth Abraham Hospital is operated on a 7 day a week basis. The laundry is staffed by 7 full time equivalent personnel and 6 of those 7 people are entitled to 4 weeks vacation, 12 holidays and 12 sick days per year. The 7th individual is entitled to 2 weeks vacation, 12 holidays and 12 sick days per year. It is obvious therefore that the 7 personnel on staff are hardly sufficient to cover for each other on their scheduled days off.

It should be further noted that the institution has been servicing the patients' clothing instead of contracting out for the service, thereby, at the same time saving from $8,000 to $10,000 per year in total costs, and serving our patients more efficiently.

The recommendation that the contract laundry be reduced by $78,000 per year is not a reasonable recommendation since the contract that the institution negotiates with the outside service is based upon the usage of linen. The Beth Abraham patient, as heretofore demonstrated, is more intensely ill than those patients it is grouped with for purposes of reimbursement and therefore requires a greater frequency of linen change and washing of personal clothing. If the institution were to lower the cost of the contract laundry, it could only be done by using less linen, which in turn could only be accomplished by changing the patients' linen less frequently, which, in turn would require that patients spend longer periods of time in soiled linen (bear in mind the high number of incontinent patients at Beth Abraham). This in turn would exacerbate skin break-downs and the development of decubiti(s) ulcers and at the same time cause the patient undue humiliation.

Our linen contract when it is renewed, is negotiated with several linen service companies, and the lowest bidder is that company which we use, bearing in mind the prudent buyer concept. Our present linen service company provides us excellent service for the lowest price available. When we asked the Health Department to find us a contractor who would produce the laundry service at their suggested cost, we were told that the Department did not know any contractor who could do so.

SOCIAL SERVICES

The professionally trained social worker is the only one who is equipped to understand the various forces playing upon the individual and his family in coping with the enormous strains of institutionalization.

Unless there is a professionally trained and adequately staffed Social Service Department, the patient and his family will be deprived of:

Pre-admission evaluation in depth of the necessity for institutionalizatio or whether a less expensive form of care can more readily meet the individual's need.

The family and patient would not get the help in facing the crisis of finances, often having to give up lifetime savings, the threat of impoverishing a spouse, etc.

Patients' problematic inter-personal relationships will not be dealt with, therefore. leading to inadequate utilization of more professionally costly personnel (psychiatry, administration, etc.)

Patients will not be motivated to use the rehabilitative and restorative services leading to less costly care.

The institutionalized patient and his relative will not have the expert assistance in effecting discharge.

The institutionalized population will be deprived of the "advocacy" role which is taken on by social work.

Lack of the professionally trained social worker will often lead to deprivation of prescribed medical care because of the needed interpretive job the social worker assumes as to the ethnic, cultural and emotional background of the patient.

Lack of adequate and trained social work staff will provide no psychosocial consultation to other disciplines; therefore leading to misunderstanding of patient behavior and resulting in more expense.

Such absence of staff will remove the individual from motivation to "live to the fullest within his disabilities".

The lack of appropriate experienced and trained social work staff will affect the institution negatively as it pertains to overall census.

Beth Abraham's history and philosophy that has been and is dedicated to people rather than profits needs no defense! The Social Work Department has made a lasting contribution to the reputation of the agency in caring for the patients, in meeting the vast needs of the relatives, and tampering with this service would be tragic.

To think that a half time secretary could handle the clerical and secretarial functions for a 504 bed institution such as Beth Abraham Hospital has been demonstrated to be preposterous.

BETH
ABRAHAM
HOSPITAL

ACCOUNTING DEPARTMENT

The State has recommended a reduction of three bookkeepers for a savings of $45,000.

It must be noted that the average salary paid to a bookkeeper with fringe benefits is approximately $13,200 - not $15,000.

It is inconceivable that the institution can function with two bookkeepers for the following reasons:

> The institution must prepare a biweekly payroll for over 600 employees plus monthly tax returns, and year end tax returns; plus distribution of checks, distribution of time cards and receive time cards, also the processing of all fringe benefits to the union and non-union offices.
>
> The Accounting Department also prepares Medicaid bills, Medicare bills, plus other patient bills, follow-up notices, postings to all books of accounts, reports to various local and State agencies, as well as other fiscal intermediaries; checking all vendor invoices, purchase orders and distributing vendor checks are also another function.

With vacations, holidays and sick time, etc. it would not be practical to operate a business office with only 2 bookkeepers.

The institution has taken steps to reduce accounting costs by eliminating 2 positions totally approximately $40,000 with fringes, and increased the work load of other individuals within the department.

In order to comply with new regulations and new forms and additional reports that the State and local governments have instituted within the past year, it seems that additional clerical help is necessary rather than to be taken away.

BETH
ABRAHAM
HOSPITAL

DIETARY DEPARTMENT RECOMMENDATIONS

The recommendations to change the institution's food delivery system from a food cart disbursement system on the patient floors to a centralized tray service working from the kitchen itself are recommendations that Beth Abraham Hospital made itself to the New York State Department of Health which the Department now takes credit for. In analyzing our food service costs the institution felt that by reorganizing the delivery methodology and limiting to a great extent the variety of menu selections available, Beth Abraham initially estimated the savings on an annualized basis of close to $100,000 per annum. The institution has already received permission from the State to begin instituting the necessary mechanical improvements in the kitchen facility that would allow the subsequent cost reductions.

It must be understood that a redesign of the kitchen facility is required, the purchasing of additional equipment with a three month lead time is required, and the retraining of the existing staff is required, which is further complicated by the union contract with Local 1199 of the Drug and Hospital Employees Union, which requires an inordinate amount of contract interpretation, bumping of positions due to bargaining unit seniority, and the reduction of many positions from full time to part time status. It is not known at this point how long these contract negotiations are going to take. The layoffs will result in additional costs such as severance pay, and the cost of unemployment insurance for each employee.

As we are experiencing some difficulty in the retraining process of our present employees, we can currently project a $60,000 savings in salaries and the approximate $10,000 savings in food costs, yielding a projected $70,000 total savings on an annualized basis, once the system is in full operation.

Bearing in mind the aforementioned problems in reorganizing the total food service at the institution, it is totally inappropriate to recommend that the position of Director of Food Service be eliminated, as that is the individual with major responsibility for designing, implementing and overseeing the total departmental reorganization. To remove its leadership would be counterproductive. He also does the purchasing and the coordination of a complex food service. The recommendation that the institution charge $2.00 per meal for employees eating at the institution is fallacious for several reasons:

1. The figure of 70,500 meals served per year has no basis in reality. The institution currently serves 26,400 meals per year at a cost to the employee of $1.25 per meal. This in turn generates $33,000 income per year. The only meal the institution provides to employees is lunch, and we are not equipped in terms of staffing to provide either breakfast or dinner to any employees.

2. The institution currently has a stipulation in its contract with Local 1199 Drug and Hospital Employees Union that any employee hired prior to 7/1/68 receives money in their paycheck in the amount that the institution charges for the meals that prior to that date had been provided free of charge. To increase the charge for employee meals to this majority of individuals who eat in our cafeteria would be cost additive as opposed to representing a savings factor.

The methodology employed by the State for the rate computation reduces the institution's overall cost by the amount of money generated by charging for employee's meals which, in turn, is a reduction of reimbursement; therefore, increasing the charge for employee meals does not generate any savings to the institution. In fact, as previously indicated, an additional charge to employees would be cost additive. It would also create an additional union problem since this is an established past practice.

SHELTERED WORKSHOP

The Work Activities Center at Beth Abraham Hospital provides various forms of activity therapy which challenge the residual physical, psychological and social capacities of the patient population. Such therapy, as well as physical and occupational therapy, is an integral part of the medical rehabilitation program at the institution.

A variety of useful work projects have been designed out of which can be selected those projects commensurate with the strength, need, endurance, speed, coordination and motivation of the individual. In addition, when properly prescribed, these activities can increase the capacities of the patients in these areas. For this reason, activities must be and are medically prescribed by attending physicians experienced in this form of medical practice and must be and are supervised by therapists specifically trained in the uses of work therapy.

MAIL AND MIMEO

The State indicates that the Mail and Mimeo Department should be reduced to one person. The institution feels that this cut is not logical since the Mail and Mimeo Department handles the following work load:

Sorts and distributes mail to all departments (incoming, outgoing and inter-office mail).

Produces all mimeo and stencil work for distribution within the institution.

Microfilming of all records.

Stocking and distributing office supplies and stationery to all departments.

The institution has been able to reduce outside printing costs and keeps a control of postage as well as control of supplies being used, which results in savings.

It is felt that if the person were taken away there would be waste and additional costs added rather than saved.

BETH
ABRAHAM
HOSPITAL

VOLUNTEER DEPARTMENT

The Director of Volunteers occupies a position of great importance at Beth Abraham Hospital. Without the 300 volunteers who render over 62,000 hours of work during the course of the year, our patients would be deprived of vital services and would make it impossible for the institution to function without additional salaried staff.

The Volunteer Director is responsible for recruitment of volunteers by reaching out to multiple agencies and schools and community groups, i.e. RSVP (Retired Senior Volunteer Program), Red Cross Youth Group, United Hospital Fund City and Parochial High Schools and Colleges throughout the City, to make them aware of our urgent need for volunteers. This is done not only through mail communications, but through radio appearances, newspapers and personal appeals at public functions and meetings with principals and students at the various schools.

The Director of Volunteers not only recruits, but is responsible for orientatio of the volunteers, for making appropriate and sensitive assignments that would be beneficial to the patient, yet not discourage the volunteer. It must be noted that our patients are seriously debilitated, incapacitated, incontinent and have terminal diseases. Volunteers in many instances find it difficult to accept such an assignment and it is only with encouragement and understanding of the patients' needs and the needs of the volunteers that we are able to succeed to the extent we do.

The Director of Volunteers establishes policies, develops attitudes, procedures and objectives of the volunteer program consistent with these policies.

In consultation with the hospital staff, plans for the use of volunteers and defines services that may be performed by volunteers.

Interprets the functions of the volunteer program to the hospital and the community.

Orients hospital staff members in the use and acceptance of volunteers.

In cooperation with other department heads and supervisors, establishes and maintains good relationships between volunteers and staff.

Assigns volunteers with consideration for balancing the needs of the patients, the hospital and the volunteers.

Establishes and conducts orientation of all volunteers to the hospital setting.

Conducts reorientation sessions and meetings to advise volunteers of developments within the hospital, to encourage discussion for improvement of the volunteer service and to review the rules and ethics of the hospital.

Organizes volunteer training programs in cooperation with the hospital staff and other organizations which train volunteers.

In cooperation with the department heads and supervisors develops job descriptions for volunteers.

Helps to promote and maintain morale of individual volunteers and their effectiveness as a group.

Maintains volunteer standards by sharing the supervision of all volunteers with the department heads and supervisors of all departments in which the volunteers work and assisting Administration with periodic appraisal of volunteer performance.

Periodically writes evaluations required by high schools and colleges for student volunteers.

Maintains contact with department heads, volunteers and employees of all departments, volunteer applicants and various community leaders and agencies.

Assists Administration in the development of a program of recognition for volunteers.

Administers the volunteer office, including the maintenance of records and preparation of reports, etc.

Prepares and submits monthly and annual reports to Administration and to the Committees and Agencies on Volunteer Services.

Keeps informed of legal regulations and legislation affecting volunteers; trends in Volunteer Service, methods of recruiting and new developments in the hospital.

Services Which Volunteers Perform for Patients:

Specially trained volunteers help to feed patients. Of the 504 patients, 38% of the patients require total feeding and 33 at least partial help. Our limited salaried staff could never accomplish this task without the help of volunteers.

Patients who would be bedfast (365 at the last count) if not lifted to wheelchairs by aides and orderlies, are wheeled by volunteers to the various clinics, rehabilitation therapy and recreational areas.

Volunteers serve juice and refreshments, shop for patients, write letters, carry messages, read and converse with patients, assist at parties and entertainment and assist with group and recreational activities.

Areas In Which Volunteers Work:

Volunteers work in the medical and dental clinics, medical library, nursing floors, occupational therapy, physical therapy, speech therapy, Work Activities Center, dietary department, housekeeping, groupwork and recreation activities, music therapy, patients' and medical library, social service and in a clerical capacity in several departments. Volunteers also work in the capacity of patients' ombudsmen.

To remove the services of volunteers which would be a direct consequence of eliminating the position of the Director of Volunteers would add to our costs and be a totally irresponsible act. Volunteers cannot function in a vacuum without direction and leadership, nor do our overworked department heads have the time to give to this function.

For your information, our Director of Volunteers was only recently presented with a Certificate of Honor from Mayor Abraham Beame for an outstanding and meritorious Volunteer Program at Beth Abraham Hospital.

BETH
ABRAHAM
HOSPITAL

PRIOR INSTITUTIONAL COST REDUCTION

In the fall of 1975, responding to an increasing fiscal deficit that was becoming unmanageable, occasioned by insufficient Medicaid reimbursement, the institution instituted a job freeze and a reduction in working hours for some of our staff.

When we found that because of low turnover of staff that we were not achieving the required savings, layoffs were instituted affecting every department with the exception of nursing and medicine that resulted in a strike by Local 1199 in February of 1976.

This strike was finally ended by a Federal court order. The following positions were eliminated or reduced during this period, prior to the current Health Department recommendations:

Dietary	2 part time - 7 full time	
Housekeeping	15 full time	
Personnel	1 part time	
Medical	1 house staff physician	
X-ray	1 radiologist reduced from full time to half time	
	1 full time aide	
Volunteer Dept.	1 full time	
Speech & Hearing	1 full time	
Social Service	3 full time	reduced in hours
Nursing clerical	1 full time	
Maintenance	5 full time	
Physical & Occupational Therapy	3 full time	
Dental	2 reductions in hours	
Beautician/Barber	2 reductions in hours	
Mail/Mimeo	1 full time	
Laboratory	2 full time	
Accounting	2 full time	
Pharmacy	1 reduction in hours	

Again in July of 1976 we were struck by Local 1199 for 8 days because we could not meet the Union's demands for wage and benefit increases. This strike was settled when all the institutions involved, and we were one of them, agreed to accept binding arbitration. The arbitration awarded mandated wage increases for the first half of 1977 that will add another $400,000 to our deficit despite the arbitrator's awareness that this would not be reimbursed by Medicaid.

Our operations are under constant review, as we look for areas in which savings can be effected without harm to our patients.

We believe that the reduction in staff and other operating costs that have been instituted, while they have had some adverse effect on patient care and the maintenance of the institution, are tolerable.

However, beyond this point, further reductions in service could be detrimental to patient care and would have to be carefully reviewed in terms of the overall effect on our operations. There is a limit beyond which we cannot tax our staff without breakdown in morale and service.

BETH
ABRAHAM
HOSPITAL

Medical Care and Rehabilitation Center for the Ch
Allerton Avenue at Bronx River Parkway, Bronx, N.Y. 10467 • 920-

William H. Frohlich
Administrator

EXHIBIT "A"

Documentation indicating the intensity of service and need for expanded medical and nursing care.

1. 4/10/73 letter to Dr. Hollis S. Ingraham with Appendix I attached.
2. 3/17/75 letter from Dr. Richard Nauen, State Department of Health re: Periodic Medical Review with summary of findings.

   3/25/75 letter to Dr. Richard Nauen with answers to summary of findings attached.
3. Statistics for 1974 on patient population.
4. Beth Abraham Hospital 1975 Patient Care Booklet.
5. 10/13/76 - Patients' Conditions Page 1 and 2.
6. 3/24/75 letter to Dr. Frank Cicero with attachments 1, 2 and 3.
7. 8/5/75 letter to Dr. Richard Nauen from Dr. Harvey C. Shapiro, our Medical Director.
8. Patient admissions for May and June, 1975.

M Barrett

#1

April 10, 1973

Dr. Hollis S. Ingraham
Commissioner
New York State Department of Health
84 Holland Avenue
Albany, New York 12208

BEST COPY AVAILABLE

Dear Dr. Ingraham:

Beth Abraham is a chronic disease hospital licensed as a skilled nursing home. Its reimbursement formula is tied to the conventional nursing homes and homes for the aged in a group and geographic area.

The institution was founded in 1920 and continued as a Home for Incurables, a nursing home, became a hospital in 1965 and returned to nursing home status in 1967 at the request of Dr. Dickson, your Deputy, who stressed the shortage of skilled nursing home beds and gave us his assurance that our reimbursement would not be affected by this reclassification.

The institution provides all of the services of a chronic disease hospital with the exception of an operating room. This enables us to admit patients requiring acute chronic and general medical care as well as rehabilitation. Patients are admitted from the ages of sixteen upward. Of our five hundred patients approximately 145 are under the age of 65.

The major hospitals in the metropolitan area, including Montefiore of which we are a division, are able to transfer chronically ill patients still too sick to go to a nursing home to Beth Abraham because we are able to provide the continuity of services and care required by these patients. Memorial Hospital, with which we have a transfer agreement at the hospital's request, and Presbyterian Hospital, regularly refer this type of patient to us.

Attached are intake summaries of our two most recent and less medically dramatic admissions. Dr. Dickson has a large file of these documents.

Recent advances in medical science have saved the lives of many chronically ill patients but left them severely handicapped and needing the full galaxy of hospital services. Having achieved this stage and being able to do nothing further for these patients, the hospitals have had to find an institution that could continue their care and maintain the continuity of treatment to prevent regression and further hoped for improvement.

These patients are being admitted to Beth Abraham, severely deteriorated and advanced in the progression of their diseases.

Appended to this letter is a description of their diseases and nursing needs as well as statistical data.

In 1971 and 1972, in response to pressure from our Nursing Department, supported by the conclusions of your survey teams, several meetings were held with Dr. Dickson and his staff to request a higher rate to enable us to bring our nursing services into line with your Department's standards. Following are quotations from these surveys:

August 4, 1971
"NURSING:

" Beth Abraham accommodates an unusually large number of persons who are totally incapacitated or have extensive physical disabilities and require multiples of repetitive nursing care and services. This was so aptly evidenced during the survey when we observed the many patients who had to use wheelchairs or were bedfast and required total care.

"A review of master staffing figures projected by the staff reflected an average of 2.38 patient care hours of service for the twenty-four hour period, when the minimum allowed by the Code is 2.5 hours. Since most of the patients are extremely incapacitated requiring total care and must use wheelchairs (census of 496 patients - 288 require total care, 433 wheelchair users), it would be more realistic to project a staffing pattern that reflected approximately three to four hours of care per patient within the 24 hour period."

August 14, 1972
"The patient population at Beth Abraham is an extremely disabled, debilitated and chronically ill group, most of whom require total nursing care and/or surveillance. Of the census of 498 patients, 305 would be completely bedfast if they were not lifted to chairs or stretchers. There were only 108 patients requiring no assistance with ambulation. In general, the patients in this institution appear to require more nursing care than the average nursing home patients."

Dr. Dickson, after carefully hearing us out, stated that he would have your New York office review their original findings and report to him, after which he agreed to take appropriate action. To our knowledge, these surveys were not done and no action was taken by Dr. Dickson.

In March 1973, at our request, the Management Service Division of the Hospital Association of New York State did a survey of our patient population. Their preliminary report is also appended. You will note that their survey indicates the need for 25 additional registered nurses and if we were to comply with the State code this number would be increased by another 15 for a total of 40.

As this increasingly sick patient population was admitted to Beth Abraham, our costs mounted but your rates kept pace with them. There came a time when it was difficult for your Department to continue making these adjustments because we were exceeding the ceiling, at which time both Dr. Dickson and Mr. McCann recommended the merger with Montefiore Hospital which I had advised them was being contemplated. They stated that in this way we would be taken out of the grouping in which we were then placed and would be reimbursed on the formula that applied to hospital related nursing homes. This permits reimbursement up to 90% of the approved hospital's costs.

The Boards of Montefiore and Beth Abraham Hospital met during 1971 and agreed to the merger of both institutions which became effective Jan. 1, 1972 and Montefiore Hospital assumed total responsibility for the operation of Beth Abraham.

Your Department acknowledged the merger by removing the ceiling factor in computing the rates for Beth Abraham and confirmed our status as a hospital related nursing home.

We were shocked, therefore, when early in December 1972 Beth Abraham received notice of a reduction in rate for the months of November and December from $54.59 per patient day to $39.98 and again in January of 1973 when we were further advised that the rate for the first six months of 1973 would be $51.83, bringing us back practically to the rate we were receiving on January 1972.

In establishing these rates the ceiling factor had again been reintroduced and no recognition was given to the rise in costs during this extremely inflationary period. When we questioned this we were told that a new formula had been devised establishing rates on a 1971 base.

We appealed this decision and met with Dr. Dickson and Mr. McCann, who advised us that if we could demonstrate that there had been a substantial change in the operation or patient mix at Beth Abraham as a result of the merger, that the ceiling factor would again be removed. This meeting was attended by Dr. Schwartz of your Department, who we were advised was an impartial observer who would visit Beth Abraham for the purpose of ascertaining these facts.

At this meeting Dr. Schwartz made several remarks expressing his prejudice with regard to Beth Abraham's costs.

Subsequently Dr. Schwartz visited Beth Abraham for this stated purpose and, according to my staff who accompanied him on his tour of the building, again expressed his prejudice. He also stated that he understood that our merger with Montefiore would add $22 a day to our costs and he saw no reason for providing the type of services we were giving to our patients. He made reference to a nursing home in Iowa where his mother was receiving excellent care at some figure like $18 a day and could not understand why we could not do this in New York.

The staff also advised me that Dr. Schwartz did not make the comparison between 1971 and 1972 that he was supposed to make and it was only at their prodding that he did more than a cursory examination. The results of his visit were a foregone conclusion. In fact, it is our opinion that he had made his decision before he arrived at Beth Abraham.

✓

304

Based on this experience I again appealed to Dr. Dickson for a further review and was advised by him that a Rate Review Board would consider our problem in March. We were not invited to appear before this Board and have no knowledge of what information they had available to them in arriving at their subsequent negative decision.

It is inconceivable to us how this decision was arrived at since the statistics definitely demonstrate that a dramatic change has occurred at Beth Abraham since the Montefiore merger. The hospital has been enabled to discharge patients who would have spent considerably longer time there to a facility that could provide the advanced services their medical needs required. While the hospital has agreements with other nursing homes, these patients could never have been transferred to them or maintained by them.

In conclusion these factors must be considered:

a) Your surveyors confirm the demanding nature of our patient population. So does the survey recently completed by the Hospital Association of New York State whose preliminary report is attached.

b) Both Dr. Dickson and Mr. McCann encouraged representatives of Montefiore and Beth Abraham to merge and made commitments to them that the Department would acknowledge this by reimbursing Beth Abraham as a hospital related nursing home.

c) This commitment was kept until December of 1972 when the Department reversed itself by reintroducing the ceiling factor and penalizing Beth Abraham and Montefiore by $2.90 a patient day. This is the only time in years of cooperative and cordial relations with your Department when the integrity of the Department's commitment is questioned.

d) The financial impact on the institution has been catastrophic. The reduction in rate for 1972 created an operating deficit of $393,561. The actual operating deficit was $538,061 but it was reduced to the lower figure by a Federation grant of $144,500. The projected deficit for 1973, after $100,000 in cutbacks in patient services, is $635,000 before an anticipated Federation grant of $150,000.

e) There appears to be prejudice by some members of the New York State Department of Health toward the merger of Beth Abraham and Montefiore. There have been comments that Montefiore's operating costs are too high and that Beth Abraham's would be escalated once it became part of Montefiore.

What actually has happened is that there have been substantial savings in operations as a result of this merger through the greater purchasing power of Montefiore Hospital and through the provision of many free services from the hospital that would otherwise have to be paid for.

We believe that there have been savings in the neighborhood of $100,000 in the year 1972 because of this.

The State of New York saves about 300% of the cost of care of patients kept in Beth Abraham who would ordinarily be sent to hospitals - the same saving applies to patients that hospitals are able to transfer to Beth Abraham who otherwise would have had to remain there. Sound fiscal thinking would indicate that it is to the State's advantage to encourage Beth Abraham to continue its intake and service programs.

If anything more intermediate hospital services of the kind Beth Abraham provides are sorely needed to contain costs of hospital care which can be managed in such a specialized institution backed up by the resources of a teaching hospital like Montefiore.

In conversations with Dr. Dickson in earlier years when reimbursement had become a problem, he had offered to relicense Beth Abraham as a hospital so that we could continue to maintain our services. Consideration might be given to this kind of action at this time if no other alternative exists that will rectify present conditions.

Finally, your Department enjoys a splendid reputation for its high standards and for its integrity. These factors must be taken into consideration.

Yours sincerely,

William Adelman
Executive Director

WA:mf
encs.

BETH ABRAHAM HOSPITAL

APPENDIX 1

TABLE 1

YEAR	TOTAL ADMISSIONS	FROM MONTEFIORE		OTHER HOSPITALS		ALL HOSPITALS		FROM OTHER	
		No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
1971	106	24	22%	36	34%	60	56%	46	44%
1972	209	71	34%	90	43%	161	77%	48	23%
1973 (3 mos. Jan.-Mar.)	83	41	49%	28	33%	69	83%	14	17%

Patients admitted to Beth Abraham Hospital by diagnosis:

TABLE 2

	1971	1972	1973 (3 mos. Jan.-Mar.)
Terminally ill - carcinoma	10	58	25
Cancer - non-terminal	2		
Neurological - inc. strokes	32	79	36
Cerebral Palsy	5	2	
Liver		1	
Heart Disease	7	29	14
Blood Disease		3	2
Renal Disease	1	3	
Arthritis	9	11	
PVD	4	14	6
Metabolic	2	4	

Severity of illness and level of nursing care needed:

Examples: (Patient census 502 - 3/9/73)

305 - non-ambulant, requiring four hours of nursing care. (Corroborated by State Code)
77 - have decubiti. (Since January 1973, 19 patients admitted with decubiti from other hospitals)
82 - require at least daily dressings for other than decubiti
45 - with Multiple Sclerosis - advanced stage of the disease
62 - with Parkinsonism - advanced stage of the disease
178 - Incontinent of bowel and bladder
36 - with terminal cancer
132 - require full assistance with eating; 140 partial assistance
9 - nasogastric feedings
77 - aphasic requiring extraordinary nursing time
83 - require Foley irrigations
87 - confused and disoriented always
107 - " " " sometimes

STATE OF NEW YORK
DEPARTMENT OF HEALTH
NEW YORK CITY OFFICE
2 WORLD TRADE CENTER
NEW YORK, N. Y., 10047
(212) 488-3939

HOLLIS S. INGRAHAM, M.D.
COMMISSIONER

EXECUTIVE DIVISION

RICHARD NAUEN, M.D.
ASSOCIATE COMMISSIONER
FOR NEW YORK CITY AFFAI

307

BF

cc: WA/PK

March 17, 1975

#2

Mr. William Adelman, Executive Director
Beth Abraham Hospital
612 Allerton Avenue
Bronx, N.Y. 10467

Re: Periodic Medical Review and Independent
Professional Review on
February 18,20,21,24,25,26,28,1975

Dear Mr, Adelman:

On the above date Medical Review personnel visited your facility and carried out periodic medical review and independent professional review as required by Federal Regulation 45 CFR 250.23.

Enclosed you will find a summary of the findings noted as to each Medicaid Title XIX beneficiary in your facility at the time of the review. In addition you will find a narrative summary of the deficiencies that were found.

Kindly submit a plan of corrective action regarding the deficiencies noted. This plan should be submitted to this office within 60 days of the receipt of this report.

Sincerely yours,

Richard Nauen

Richard Nauen, M.D.
Associate Commissioner

Encl.

cc: Chairman, URC
Dr. John Gentry
Mr. George Smith
[illegible]

SEE NEXT PAGE

MAR 20 197

Beth Abraham Hospital **Survey date: February 18, 20, 21, 24, 25, 26, 28, 1975**

Summary of Findings

I. Record Review

A review of 507 records revealed the following:

Medical evaluation was inadequate in 23 records. A fully developed physician's plan of care was lacking in 336 records; so physician's plan of care could not be carried out. Seven nursing care plans lacked documentation of pertinent nursing diagnosis and nursing orders. Nurses notes did not reflect nursing care plans in eight instances. Progress notes on patients receiving physiotherapy were not reviewed once in 30 days by the physician in three records. Twenty two records contained inadequate nurses notes which failed to give a total picture of these patients. There was no documentation of individualized social needs on 19 patients. Twenty two records lacked current notations on social work. Twenty four patients had excessive weight losses and 13 had excessive weight gains within a short period of one or two months. Seven orders by the physician did not contain specific instructions.

II. Patient Observation

On making rounds in the patients area, patients appeared to be clean and properly dressed.

III. Appropriate Placement

Eight patients appeared to be inappropriately placed in that they might be considered for placement in an HRF.

IV. Special Observation

NOTE

Though this institution is classified as Skilled Nursing Facility many patients are acutely ill requiring total care. Patients in three floors viz., 2P2 and BR2, BR3 can be easily classified as chronic hospital patients. In view of the heavy demand for more nursing hours on these floors, other floors are deprived of sufficient nursing staff. It is mainly because of the excellent, hard-working and devoted medical and nursing staff, both administrative and practitioners, that the patients are getting the needed care. Nursing staff is working under pressure and the attrition rate among the nursing staff is too big to put off anymore sanctioning of additional staff to this institution. In the interest of continued and satisfactory care of the special type of patient population of this facility it is highly essential to take action to obtain sanction for additional staff to this facility.

March 25, 1975

Dr. Richard Nauen
Associate Commissioner
New York State Department of Health
New York City Office
2 World Trade Center
New York, N.Y. 10047

Dear Dr. Nauen:

Enclosed is the reply to your letter of March 17, 1975 regarding Periodic Medical Review and Independent Professional Review on February 18, 20, 21, 24, 25, 26, 28, 1975.

Sincerely yours,

William Adelman
Executive Director

WA/nj
Encl.

BETH ABRAHAM HOSPITAL

Re: Letter of March 17, 1975 - Periodic Medical Review and Independent Professional Review on February 18, 20, 21, 24, 25, 26, 28, 1975

Summary of Findings

1. Record Review

The Medical Department has been made fully aware of your comments and while, as stated previously, the physicians' plansof care was included in the interdisciplinary patient plan of care documented on the Kardex, all physicians will now record the plan of care on a specially prepared form which will be part of the patients' chart and will be frequently reviewed.

Several inservice training sessions on all tours have already been conducted and more are planned to further instruct nurses in writing more meaningful and complete nurses' notes. Guidelines have also been developed for writing weekly summaries. Patient care plans are being Being reviewed with nursing staff and all other disciplines. Physicians, nurses and social workers have been apprised of the omissions referred to in your report and immediate corrections will be made. Physicians are in the process of evaluating weight losses and excessive weight gains.

III. Appropriate Placement

Of the eight patients referred to, in two instances attempts had already been made for return of the patients to their own home, and this is expected shortly; two others are awaiting placement in a suitable facility.

The four other patients were reviewed by the Utilization Review Committee with the following comments:

In one instance, it was felt that patient with a diagnosis of multiple sclerosis, deep decubiti and paraplegia required continued care at Beth Abraham Hospital.

One patient has since been temporarily transferred to an acute hospital because of reactivation of multiple myeloma.

One patient would be bedfast if not lifted and requires help in all areas of A.D.L. No health related facility would accept her according to present standards.

One patient, it was felt, would be deeply, emotionally traumatized if a transfer were to be effected. She has had several episodes of severe anxiety neurosis requiring psychiatric consultations relating to any move and has been a patient here of long duration. Further consultation will be sought.

Special Observations

The letter previously sent to Dr. Frank Cicero, Deputy Commissioner with a copy to you dated March 25, 1975 indicates our efforts to add additional staff. We request your assistance with the leadership in Albany.

311

#3

BETH ABRAHAM HOSPITAL

SUMMARY OF ADMISSIONS FOR 1974

NUMBER OF ADMISSIONS		303
ADMITTED FROM:	Hospital	271
	Nursing Home	7
	Other	25
	Total	303

DEATHS AND DISCHARGES	Within 3 mos.	Within 6 mos.	Within 1 year
Patients Died	134	34	11
Patients Discharged			
Hospital	19	1	1
Nursing Home	1	1	
Other	2	2	
	22	4	1

Patients Remaining

TOTAL

LEVEL OF CARE		(303 PATIENTS) ON ADMISSION	LEVEL OF CARE STILL REQUIRED (97 PATIENTS AS OF 2/28/75)
Walks alone		15	7
Walks with help		42	19
Needs lifting		145	82
Uses wheelchair		187	89
Propels wheelchair		113	59
Cannot propel wheelchair		79	45
Completely bedridden		84	13
Dressing:	No help needed	10	6
	Need some help	105	48
	Need complete help	178	64
Eating:	No help needed	69	36
	Need some help	118	43
	Need complete help	42	17
Alert		139	62
Coma		29	6
Confused at times		49	25
Confused all the time		44	23
Blind both eyes or legally blind		31	7
Serious hearing problem		26	6
Deaf - cannot hear at all		4	0
No verbal communication (includes aphasia, confused, critically ill)		113	46
Incontinent bowel		151	68
Incontinent bladder		199	74
Foley catheters		102	29
Foley irrigations		102	27
Texas catheter		38	22
Colostomy & colostomy care		10	2

BETH ABRAHAM HOSPITAL - 2

SUMMARY OF ADMISSIONS FOR 1974

312

LEVEL OF CARE (Cont'd.)	(308 PATIENTS ON ADMISSION	LEVEL OF CARE STILL REQUIRED (97 PATIENTS AS OF 2/28/75)
Water mattress	113	32
Oxygen	32	6
Tracheostomy	15	5
Frequent suctioning	30	6
Decubiti dressings	124	19
Other dressings	74	13
Ureterostomy & ureterostomy care	3	1
Nasogastric tube feeding	64	24
Gastrostomy feeding	8	2
Intravenous therapy	14	3
Oral medications	297	90
Intramuscular injections	40	12
Subcutaneous injections	32	8
Turning patient every 2 hours	132	49
Enemas per week	58	24

3/4/75

BETH ABRAHAM HOSPITAL - TAKEN FROM PATIENT CARE BOOKLET - 1974

NURSING DEPARTMENT
(as of December 31, 1974)

313

Ambulation	Patients	Percent
Non ambulant (require lifting)	356	72
Semi-ambulant	97	19
Ambulant	43	9
	496	100

Of the above, 413 patients require wheelchairs - approximately 83%.

Mental Condition	Patients	Percent
Confused all the time	79	16
Confused at times	135	27
Alert	282	57
	496	100

Eating	Patients	Percent
Need complete help*	120	24
Need some help	161	33
Need no help	215	43
	496	100

Dressing	Patients	Percent
Need complete help	293	59
Need some help	133	27
Need no help	70	14
	496	100

INCONTINENT	Patients	Percent
Bladder and Bowel	164	33
Bladder alone	49	10
Bowel alone	6	1
Total indwelling catheters	101	20
Colostomies	8	2
NO VERBAL COMMUNICATION Includes aphasic, confused and comatose patients	89	18
COMPLETELY OR PARTIALLY DEAF	32	7
BLIND AND LEGALLY BLIND	23	5

*Nasogastric Feedings - 30

BETH ABRAHAM HOSPITAL

Nursing Department

314

	Census 36	Census 36	Census 37
	1 BR	2 BR	2 ZP
Patients to feed	16	14	8
Nasogastric Tubes	2	4	28
Decubiti	15	15	21
I. V. Therapy	1	0	2
Dressings (other than decubiti)	6	9	2
Oxygen - running	1	2	2
Oxygen - on standby	4	2	7
Number of catheters	12	13	23
Texas catheter	4	9	8
Number seizure patients	4	3	11
Tracheostomies	0	2	6
Treatments -	12 Foley irrigations	13 Foley irrigations	23 Foley irrigations
	1 Enema	1 Nephrostomy	5 Tracheostomy care
	1 Sitz bath	1 Colostomy	
	5 Ointment to skin lesions	8 Ointment to skin lesions	4 Ointment to skin lesions

3/3/75

315

[illegible] Census [illegible]/76

If pt. [illegible] colostomy he is
incontinent of bowel unless self care

Unit	Census	Ambulation (must = census)			W/C Status (must = [illegible])		[illegible]		[illegible] (must = census)			Eating (must = census)				Mental Status (must = census)				Communication (must = census)						
		Non-Ambulant	Semi-Ambulant	Ambulant	Uses W/C	Does not use W/C	Propels W/C	Does not propel W/C	Complete help needed	Some help needed	No help needed	Complete help needed (and. N/G [illegible])	[illegible]	[illegible]	[illegible] feeding	Alert	Sometimes confused	Always confused	Coma	Verbal	Non-Verbal	[illegible]-written	Severe hearing [illegible]	Deaf	Critical	Ex: urine
2[illegible]	37	36	1	0	26	11	0	26	37	0	0	9	1	0	2	0	8	17	12	7	30	3	2	0	1	5
3[illegible]	34	27	7	0	32	2	6	26	32	2	0	19	[illegible]	[illegible]	0	[illegible]	21	12	1	5	29	1	0	1	1	[illegible]
4[illegible]	37	14	23	0	35	2	20	15	27	10	0	18	6	21	0	6	12	19	0	14	23	3	3	0	0	4
5[illegible]	37	32	4	1	36	1	16	20	31	6	0	10	[illegible]	(0)	0	16	14	7	0	31	6	2	0	0	0	4
6[illegible]	37	31	6	0	36	1	19	17	35	1	1	10	[illegible]	(20)	0	19	10	8	0	33	4	3	1	1	0	4
7[illegible]	31	18	7	6	25	6	17	8	21	10	0	6	10	(9)	0	16	13	2	0	29	2	0	1	0	1	5
Sub-Tot	213	150	48	7	[illegible]0	23	78	112	183	29	1	72	[illegible]	[illegible]	2	57	78	65	15	119	94	12	7	2	3	21
1[illegible]	36	32	3	1	33	3	9	28	30	5	1	10	1	[illegible]	3	17	13	5	1	26	10	1	0	0	1	5
2[illegible]	[illegible]	[illegible]	1	0	27	9	5	22	35	1	0	10	[illegible]	[illegible]	0	13	11	10	2	19	17	2	0	0	7	6
3[illegible]	[illegible]	2	32	2	34	2	32	2	18	16	2	1	[illegible]	[illegible]	0	[illegible]	2	0	0	35	1	0	3	3	2	7
4[illegible]	36	2	32	2	33	3	30	3	9	22	5	1	13	(20)	0	29	7	0	0	33	3	0	2	0	0	7
5[illegible]	37	12	24	1	36	1	23	13	34	2	1	10	17	(9)	1	17	19	1	0	35	2	1	1	0	0	5
6[illegible]	37	7	29	1	36	1	29	7	32	5	0	10	27	(0)	0	36	1	0	0	35	2	2	0	1	0	1
7[illegible]	37	2	32	3	34	3	32	2	16	15	5	0	12	(5)	0	37	0	0	0	33	4	1	2	2	0	5
8[illegible]	[illegible]	1	33	1	33	2	33	0	18	17	0	2	27	(5)	0	20	12	2	1	31	4	0	4	4	1	6
Sub-Tot	[illegible]	[illegible]3	186	11	266	24	[illegible]	77	192	[illegible]	14	53	[illegible]	[illegible]	4	[illegible]03	65	18	[illegible]	247	43	7	12	10	11	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	375	113	15	[illegible]	[illegible]	[illegible]	6	[illegible]	143	83	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Census: [illegible] Date: 10/13/76 [illegible] Nursing Hospital

-2-

Unit	Concus	Ureterostomy	Texas catheter	I. P. catheter	Foley catheter	Bladder irrig.	Incontinent-bladder only	Colostomy care	Incontinent-bowel only	Incontinent both	Bowel & bladder training	Special skin care	No. of Decubiti	Water mattress	Requires turning often in bed	Complete bedbath	On IM's	I.V. Meds.	Oral Meds.	I.M. Injections	S/Q Injections	No. enemas p/wk.	Dressings (exclude decubiti)	Tracheostomy	Suctioning	Continuous Oxygen	PRN oxygen	Vital signs	Seizures	Pacemakers	Complete care	Partial care	Self care	# C H needed
2[illegible]P	37	0	8	3	24	25	0	0	0	36	1	5	19	31	36	11	0	1	36	2	4	19	3	6	8	1	8	24	10	0	37	0	0	1.0
3[illegible]P	34	0	0	0	2	2	0	0	0	34	0	7	3	1	16	0	1	1	32	2	1	9	0	0	0	1	0	2	6	0	34	0	0	1.0
4[illegible]P	37	0	4	1	6	7	1	1	0	27	2	13	3	4	13	0	0	0	37	0	1	0	2	0	0	0	0	7	5	0	32	5	0	[illegible]
5[illegible]P	37	0	3	0	3	3	0	1	3	15	2	0	1	0	0	0	0	0	35	2	0	13	0	0	0	0	1	5	3	1	35	2	0	1.09
6[illegible]	37	0	4	0	11	11	1	0	0	20	2	1	2	1	0	1	1	1	37	2	3	5	0	0	0	0	1	3	0	2	36	1	0	1.51
7[illegible]	31	0	2	0	3	0	0	0	0	7	0	2	0	0	0	0	0	0	27	1	2	0	5	0	1	0	0	3	5	0	19	11	1	1.19
[illegible]-Tot	213	0	21	4	49	48	2	2	3	147	7	28	28	37	73	12	2	3	204	9	11	46	10	6	9	2	10	44	29	3	193	19	1	2.74
1[illegible]	36	0	1	0	27	0	0	0	0	31	2	5	14	23	25	3	0	0	35	2	3	4	5	1	4	1	1	7	4	1	31	5	0	2.12
2[illegible]	35	0	2	1	25	23	0	1	0	29	1	5	19	28	32	9	4	3	36	1	6	7	2	1	5	1	5	19	3	1	35	1	0	[illegible]
3[illegible]	35	0	0	0	1	1	2	0	1	0	3	10	3	0	5	0	0	2	33	4	4	4	4	0	0	1	2	4	2	0	4	30	2	2.16
4[illegible]	36	0	3	1	4	5	7	2	1	1	1	3	1	2	1	2	0	0	35	0	7	3	4	0	0	0	3	6	1	1	7	25	4	2.27
5[illegible]	37	0	6	1	9	9	2	2	1	23	1	2	5	3	13	0	0	0	37	4	0	18	3	0	0	0	2	7	2	0	34	2	1	1.81
6[illegible]	37	0	3	1	8	7	1	1	0	17	3	9	7	3	14	0	0	0	36	0	0	12	2	0	1	0	0	6	0	0	32	5	0	1.72
7[illegible]	37	0	0	0	1	1	3	1	3	0	3	7	3	0	6	0	0	0	35	1	4	0	0	0	0	0	0	1	0	0	1	33	3	1.97
8[illegible]	35	0	5	0	3	3	2	0	0	14	1	7	1	0	2	1	0	1	34	0	4	6	4	0	0	1	0	4	2	1	19	16	0	[illegible]
[illegible]-Tot	290	0	20	4	78	49	17	7	6	115	15	48	53	59	98	15	4	6	281	12	28	54	24	2	10	4	13	54	14	4	163	117	10	[illegible]
Total	503	0	41	8	127	97	19	9	9	262	22	76	81	96	171	27	6	9	485	21	39	100	[illegible]	8	19	6	23	98	43	7	356	136	11	[illegible]

BEST COPY AVAILABLE

ETH
BRAHAM
OSPITAL

Medical Care and Rehabilitation Center for the Chronically Ill
Allerton Avenue at Bronx River Parkway, Bronx, N. Y. 10467 • 920-600

Copy

317

#6

March 24, 1975

Dr. Frank Cicero
Deputy Commissioner
New York State Department of Health
84 Holland Avenue
Albany, New York 12208

Dear Commissioner Cicero:

Shortly before Commissioner Donald Dickson retired I discussed with him the restoration of hospital status for our institution. This request was consistent with an earlier commitment from Dr. Dickson when we gave up hospital classification at his request.

Dr. Dickson advised me that he consulted with Commissioner William McCann who suggested that it would be preferable that Beth Abraham Hospital continue as a nursing home but that if your survey team were to determine that Beth Abraham had an unusually sick population requiring and receiving a hospital type service, consideration would be given to removing the ceiling from our rate to enable us to add the staff and services required by these patients.

Your survey teams have confirmed the nature of our patient population as evidenced by their recently completed reports and after consultation with our nursing leadership jointly agreed that we must employ an additional 60 or more nurses in order to reach your Department's minimal standards for proper care of our patients.

If you will check your files and the enclosed attachments you will note that we have visited and been in communication with your Department since 1971 requesting this consideration which to date has been consistently denied us.

We find ourselves now with the report which is a public document with great implications for justifiable public condemnation of the New York State Health Department and my institution, since almost 98% of our patients are on Medicaid.

It would be in the best interests of our patients and our organizations to arrange a meeting of your surveyors, my staff and your office at your earliest possible convenience to formulate a logical solution to the problems that your staff have delineated.

Dr. Frank Cicero March 24, 1975

Since the surveyors' reports have also been forwarded to the Bureau of Health Insurance and the Department of Social Services, we are sending them copies of this correspondence.

Please, let's resolve this quickly.

Yours sincerely,

William Adelman
Executive Director

WA:mf
encs.*

cc: Dr. Richard Nauen
Mr. William McCann
Bureau of Health Insurance , Mr. A. Saperstein
Department of Social Services , Commissioner James R. Dumpson

* 1. Memo re review of Medicare Medicaid Surveys, etc.
2. Memo re nurses reasons for leaving dated 2/27/75
3. Master Staffing Plan (floor staff)

cc: Mrs. Gole

BETH ABRAHAM HOSPITAL

TO: Mr. William Adelman

DATE: March 20, 1975

FROM: Elsie Goll

C.C.

SUBJECT:

Attachment 1.

I reviewed the report of the Medicare/Medicaid Survey from the New York State Department of Health dated February 24, 1975 and our reply, the letter from Dr. Richard Nauen dated March 13, 1975 and the report of the Periodic Medical Review and Independent Professional Review dated March 17, 1975, all with particular reference to Nursing Services.

Recapitulating to 1971, the surveyors' reports have always indicated that the patients at Beth Abraham Hospital are more debilitated and incapacitated than at any other institution bearing our type of licensure and that as a matter of fact, they would not admit patients requiring that high level of care. Their survey reports have always recommended the need for additional nursing staff and I quote:

"AUGUST 4, 1971 - NURSING:

"Beth Abraham accomodates an unusually large number of persons who are totally incapacitated or have extensive physical disabilities and require multiples of repetitive nursing care and services. This was so aptly evidenced during the survey when we observed the many patients who had to use wheelchairs or were bedfast and required total care.

"A review of master staffing figures projected by the staff reflected an average of 2.38 patient care hours of service for the twenty-four hour period, when the minimum allowed by the Code is 2.5 hours. Since most of the patients are extremely incapacitated requiring total care and must use wheelchairs (census of 496 patients - 288 require total care, 433 wheelchair users), it would be more realistic to project a staffing pattern that reflected approximately three to four hours of care per patient within the 24 hour period."

x10

OUR REPLY: April 4, 1971:

"We welcome your recommendations for a staffing pattern in the Nursing Department which would project approximately three to four hours of care per patient within the 24 hour period.

"We are now in the process of revising our staffing pattern for the Nursing Department to allow for this change. However, because of budgetary restrictions, this cannot be implemented unless there is a change in our daily rate by the State Department of Health. We will submit these projections when completed to Mr. William McCann, Assistant Commissioner, State Department of Health and request a change in our daily rate."

TO: Mr. William Adelman DATE: March 20, 1975

FROM: Elsie Goll C.C.

SUBJECT: PAGE TWO

In 1973, the surveyor again commented on the need for additional nursing staff and stated she would submit a complete report to the New York State Department of Health to substantiate this.

In 1974, the following was received and I quote:

"NURSING SERVICES - 405.1124 (b)(4)

"1. The director of nursing has limited input as far as budgeting is concerned. She must work within the budget that administration assigns to nursing.

"2. Nursing care hours are inadequate to adequately meet the needs of the large number of dependent patients."

OUR REPLY:

"1. & 2. The nursing director does make recommendations for a staffing budget but because of the reimbursement rate limitations, her needs cannot be met. Your Department has refused to recognize, despite our repeated pleas of the past two years, the need for a larger nursing service required by our patients' needs."

In spite of our appeals to Dr. Donald Dickson, Mr. William McCann and other officials in Albany by letter, memorandum, and personal visits, our pleas have been to no avail. We were never granted a rate increase to add the necessary additional nursing staff recommended by our staff and by your Department. For the last three years, we have been admitting the sicker and sicker patient, thus alleviating the necessity for continued stay in an acute hospital setting where rates vary from $175 to $225 per day, and relieving the State, City and the Federal Government of a huge financial obligation.

I am aware that you never ceased making known to the State Health Department our need for additional nursing staff and as a result of your conversation with Mr. Andrew Krieger prior to the last survey, he stated that he would charge the surveyors with the task of verifying and substantiating the need for more nurses as requested by us and their previous survey team.

As you know, on March 6, 1975, following the surveys, Miss Louise Macchia, our Director of Nursing Services and I conferred with Mrs. Lillian Kaplan and members of her team at the regional office of the New York State Department of Health, in an effort to establish together, or at least confirm what we considered to be a minimum number of nursing staff required to care for our very sick patients. Attached is a copy of the master plan for floor staffing we all agreed upon. We used the New York State Code formula and it represents only the minimum requirements, but indicated the need for 63 additional nurses.

TO: Mr. William Adelman DATE March 20, 1975

FROM: Elsie Goll C.C.

PAGE THREE

SUBJECT:

Ms. Kaplan stated that she would submit this staffing plan together with her report and recommendations to Dr. Richard Nauen and urged us to immediately begin employing the additional licensed nurses to correct the deficiencies. When the official report was received from Dr. Nauen's office, and I quote:

"V. NURSING SERVICES (405.1124)

"1. Approximately 75% of the patients in this facility are non-ambulatory. 50% are grossly debilitated and confused. All of these patients rely totally or in part on the nursing staff for all areas of care. Considering the large numbers of tube feedings to be accomplished and the amount of time spent in the administration and recording of medications and treatments, in addition to those non-nursing functions that would ordinarily be assigned to a ward clerk, it is unrealistic to believe that the limited number of professional nursing personnel on each unit could adequately accomplish those functions encompassing "skilled nursing care" for these chronically ill patients in a given tour of duty. There are no written, individualized bowel and bladder training programs, although several records revealed that some patients were being toileted at regular intervals. Patients were seen sitting, inactive and staring, in wheelchairs, in the corridors for an entire morning in some patient areas. There is little or no interaction between patients and nursing staff, as the amount of work to be done and the level of care to be given leaves no leeway for this type of involvement. Programs for patient/staff interaction are underway, however, it was observed that, with the approach of the noon hour, some patients had still not received morning care, and it is inconceivable that such programs could be successful without benefit of additional staff. (c) 2.

We replied as follows:

V. NURSING SERVICES (405.1124)

"1. Since 1971, we have been appealing to your Department, based on the conclusion of your surveyors and our own evaluation for additional funds to add the nurses we know that we need at Beth Abraham. There are ample records in your Department which have been shared with Dr. Donald Dickson, Mr. William McCann and other officials, documenting the need for a larger nursing staff over the years. We will begin recruiting nurses as soon as we have assurance from you that the increased cost will be met through a proper reimbursement rate to be established by your Department. We hope that at this time you will accept your surveyor's recommendations and correct this unfortunate situation. (see attached)

322

TO: Mr. William Adelman DATE: March 20, 1975

[illegible] Elsie Goll C.C.

PAGE FOUR

SUBJECT:

REPLY (CONT'D.): ATTACHED NOTE - NURSING SERVICES (405.1124) RE: [illegible]

"At a conference at the State Department of Health on March 6, 1975, with Mrs. Lillian Kaplan, Mrs. Enid McCoy and others of your department, and with Nursing Administrative Staff of Beth Abraham, a master staffing plan for the Nursing Department was formulated.

We will begin employing some of the additional staff nurses recommended in anticipation of a formal commitment from your Department that it will make the necessary adjustment in our rate to meet the cost of the staff. We were assured by your consultants at the New York City Office that after additional staff is employed, we would be reimbursed. Upon confirmation from Mr. William McCann's office, the remaining nurses recommended will be employed. The New York City Office of the Health Department is forwarding to Albany their staffing recommendations."

You also followed with a call to Mr. William McCann's office to inform him of the report from Dr. Richard Nauen and our reply and were told not to add any staff until Mr. McCann assured you of reimbursement. To date, there has been no response from Mr. McCann, though it was stated that a representative of the Department would call the next day regarding this matter.

A letter dated March 13, 1975, was received from Dr. Nauen in response to our deficiency plan of correction letter dated March 6th and attachment dated March 7th (see above) which followed our meeting with Mrs. Kaplan, and I quote:

"V. NURSING SERVICES - (405.1124) - PARTIALLY ACCEPTABLE

"Personnel must be employed before any reimbursement can be given. After the needed nursing personnel are employed a request for the increased rates should be forwarded to Mr. William McCann's office, at that time it must indicate the numbers and types of personnel that have been employed.

"The regional office cannot guarantee payments for additional costs of personnel. When we receive a request from Mr. McCann's office for verification of need, we will respond to this request. (c) 2, (e)."

On Ma0ch 20, 1975, we received a further letter from Dr. Nauen with the report from the Periodic Medical Review and Independent Professional Review on February 18, 20, 21, 24, 25, 26, 28, 1975 and the following portion is quoted:

BETH ABRAHAM HOSPITAL

TO: Mr. William Adelman

DATE: March 20, 1975

C.C.

FROM: Elsie Goll

PAGE FIVE

SUBJECT:

IV. SPECIAL OBSERVATION

> "Though this institution is classified as Skilled Nursing Facility, many patients are acutely ill requiring total care. Patients in three floors viz., ZP2 and BR2, BR3* can be easily classified as chronic hospital patients. In view of the heavy demand for more nursing hours on these floors, other floors are deprived of sufficient nursing staff. It is mainly because of the excellent, hard-working and devoted medical and nursing staff, both administrative and practitioners, that the patients are getting the needed care. Nursing staff is working under pressure and the attrition rate among the nursing staff is too big to put off anymore sanctioning of additional staff to this institution. In the interest of continued and satisfactory care of the special type of population of this facility, it is highly essential to take action to obtain sanction for additional staff to this facility."

Relating to the above, I am resubmitting memorandum to you dated February 27, 1975 which outlines reasons for high turnover of nurses at Beth Abraham.

It is quite sad that an institution like Beth Abraham that cares for the most seriously ill and terminal patients, young and old, and within the realm of our inadequate reimbursement rate renders a very high level of medical and nursing care in addition to other essential services - is subjected to criticism by State surveyors - and very correctly so, - and we laud them for their devotion and dedication to a high level of patient care - as a result of failure of the New York State Department of Health to establish the rate necessary to give the care we and they feel our patients deserve and require.

Our public image suffers greatly throughout the country since reports go to the Department of Health, Education and Welfare, the Bureau of Health Insura the Department of Social Services, - all a matter of public record - and we a helpless to correct the deficiencies by our good will alone. I feel we are shunted around between the Albany Office and the New York State Office. In the meantime, our patients suffer and those who render the vital and direct care to patients - the nurses - continue to leave us because of the overwhelming burden we place upon them. Unless there is change soon we can expect additional problems from our nursing staff since they are now in the union.

Do you think that an attempt once again to personally meet with Mr. McCann and any members of his choice from the New York Office would be of any assistance in resolving this pressing and long standing problem once and for all?

*Note: Should be BR1

BETH ABRAHAM HOSPITAL

TO: Mr. W. Adelman, Mr. W. Frohlich

DATE: February 27, 1975

FROM: Elsie Goll

C.C. Miss L. Macchia
Mrs. I. King

SUBJECT:

Attachment 2.

During the year 1974, there was a turnover of 41 nurses - almost 50% of authorized nursing staff during that year. Twenty-eight of the 41 nurses were employed here for less than six months and six less than one year. In exploring the reasons for this large turnover, the following is submitted by Louise Macchia, Director of Nursing Services and her Assistants:

1. Because most of the Nursing Units (eleven of the fourteen) have authorized staffing of one nurse on each shift, a new employee cannot be assigned a permanent station and must be used as a floating relief nurse. Though attempts are made to assign her to rotate on two or three units so that she can be more familiar with the patients and the multiple duties, this is not always possible.

2. Some of the responsibilities and pressures for every nurse - for the regular nurse and compounded immeasurably when it is a float nurse are as follows:

   Orders drugs

   Orders supplies

   Pours medications

   Charts medications

   Gives medications

   Performs all treatments

   Charts treatments

   Checks doctors' orders

   Carries out doctors' orders

   Assists the doctor

   Makes rounds periodically

   Sees that patients are sent to appointments promptly

   Special charting on very ill patients

   Checks narcotics, hypnotics

   Supervises meals re: feeding etc.

BEST COPY AVAILABLE

TO: Mr. W. Adelman, Mr. W. Frohlich

DATE: February 27, 1975

FROM: Elsie Goll

C.C.: Miss L. Macchia
Mrs. I. King

SUBJECT:

2. (Continued)

Renders direct patient care

Performs clerical duties

Develops nursing care plans

Coordinates patient evaluations on unit re: patient care plans with other disciplines

Admits and orients the new patient

Relates to patients and relatives

Attends inservice meetings of new staff, staff meetings, patient evaluation conferences, drug audits, etc. Each meeting lasts at least one hour. Unfortunately, they are viewed as an additional burden by the nurse and she attends reluctantly.

Schedules staffing for unit

Supervises, directs, guides, counsels, teaches and has organized meetings with floor staff

Organizes and involves ancillary staff in floor programs

3. Indirectly and directly, it has been stated that nurses leave because There is too much work here and not enough staff .

4. Nurses refuse to work overtime on request because they say they're too tired and need their two days off to rest. (There was a time when R.N.'s rarely refused to work overtime to make extra money).

5. Nurses state they would like to write good nurses' notes and good nursing care plans but they don't have time to put any thought into it.

6. Nurses state they do not have time to read a patient's chart or talk to a patient because there's too much other work to be done.

7. Head nurses ask Who am I head nurse of? Myself?" A head nurse implies that there are other nurses under her jurisdiction.

8. A nurse on orientation said "The patients on 1BR and 2ZP (the floors to which she was assigned) are like hospital patients".

Mr. W. Adelman, Mr. W. Frohlich 326 DATE: February 27, 1975

Elsie Goll C.C. Miss G. Macchia
Mrs. I. King

SUBJECT:

9. A newly hired nurse that worked here about 1½ - 2 years ago said, "The picture has certainly changed since I was here last. There was no 1BR or 2BR as such when I was here before. 2BP really looks like a hospital now - before we called it a hospital floor but patients were in much better condition."

10. A nurse on orientation was perplexed and overwhelmed when she came here. She said she didn't realize the patients require so much nursing care and that they are sicker and need more care than hospital patients - where they have many nurses on each unit in addition to ancillary staff.

11. Nurses on the units must assist with orientation and are sometimes angry at the additional burden of orienting. They complain to the new nurse, giving her a feeling of intruding and disrupting her routine. This fosters insecurity in the new nurse and sometimes before her orientation is completed, she resigns from the job.

12. Young nurses find chronically ill patients too depressing.

13. Frustration and lack of job satisfaction.

14. Nurses who were employed prior to July 1, 1973 (past practice) have every other week-end off. Nurses engaged after that date work two out of three week-ends. Though they are told this both by Personnel and Nursing Departments at the time of interview and agree to this policy, the reality of seeing and working side by side with the nurse who does have every other week-end off soon brings hostility and resentment and in some instances, nurses have left because of this. Our policy should be adjusted to every other week-end off which is the coming trend in all institutions, but to do this additional nurses must be added to the staff.

15. Additional Supervisory Staff is needed because Charge and Head Nurses in many instances have demonstrated weak leadership qualities and need much guidance and assistance from the Administrative Assistants.

16. There is also a need for an Inservice Instructor to assist the Inservice Training Coordinator.

In addition to all the foregoing, the situation grows steadily worse because we are admitting sicker and sicker patients - a goal we are committed to. Attached is a recommendation by unit and by shift for additional nurses to be added to the staff to alleviate the serious problem we face each day.

Prepared per
Kaplan NYS
staff on 3/6/75
Unaccepted
Director NY

327

Attachment 3.

Beth Abraham Hospital

Nursing Department

(Excludes Nursing Administration Staff)

Master Staffing Plan

Floor Staff

496 patients (patient census on 12/31/74) need 1,661 nursing care hours per 24 hours.

356 patients require 4 nursing care hours per 24 hours = 1,424 nursing care hours

97 patients require 2 nursing care hours per 24 hours = 194 nursing care hours

43 patients require 1 nursing care hour per 24 hours = 43 nursing care hours

1,661 total nursing care hours per 24 hours.

1,661 total nursing care hours x 7 days = 11,627 nursing care hours per week.

11,627 nursing care hours per week ÷ 35 hours worked per week = 332.20 persons per week.

332.20 persons per week x 40 days (vacations, holidays, sick days) = 13,288 number relief days needed per year.

13,288 ÷ 200 average number working days per year = 66.44 relief persons needed.

332.20 persons per week + 66.44 relief persons = 398.64 persons needed on staff.

1,661 nursing care hours per 24 hours ÷ 7 hours = 237.28 persons needed per 24 hours.

3/10/75

Note: Our master plan for floor staffing at the present time (3/6/75) is 335 and 398.64 is recommended - a need for 63.64 additional nurses using the staffing pattern recommended by the New York State Department of Health formula.

328

#7

BETH
ABRAHAM
HOSPITAL
Medical Care and Rehabilitation Center for the Chronically
Allerton Avenue at Bronx River Parkway, Bronx, N. Y. 10467

Medical Department

August 5, 1975

Dr. Richard Nauen
Associate Commissioner
Office of the New York City Affairs
2 World Trade Center
New York, N. Y. 10047

Dear Dr. Nauen:

Cost-effectiveness and quality medical care are two major principles for which all health care providers must be held accountable. A genuine test of administrative skill and proficiency demands that each factor be dealt with independently, and thereby derive the highest standard of quality care with an acceptable cost-efficiency ratio.

Were the various parameters of quality medical care graphically plotted against any given set of standards for all the "skilled nursing facilities", a Gaussian-type distribution curve would be predicted. The major area of the curve would define the performance of 90% of all "skilled nursing facilities", with 5% functioning at either extreme. Thus, despite the designation of "skilled nursing facility", 5% of such institutions would function as chronic disease hospitals, and a similar number would function at the level of nursing homes. One might therefore seriously question the justification for adopting either a uniform reimbursement or professional staffing policy for all "skilled nursing facilities", regardless of institutional need or standards of care.

Chronic disease hospitals, such as Beth Abraham, serve the community by providing seriously ill patients with quality medical care during an interval of their illness when they no longer qualify for sophisticated coverage provided by acute hospitals. Optimal care for patients residing in chronic disease hospitals, requires a substantial commitment of physicians, nurses, supporting services, laboratories and greater program diversity. Consistent with the initial concept of maintaining high standards of quality medical care in any given institution with an acceptable cost-effectiveness for the entire industry, the overall cost must be counterbalanced by a significantly smaller investment for "skilled nursing facilities" with a lower performance, i.e. nursing homes.

In the absence of any established standard for determining objectively the severity of patient illness, the attached unselected list of all patient admissions to Beth Abraham Hospital for the two preceding months is hereby submitted. The multiplicity of patients' diagnoses reflects the overlapping of one chronic illness with another. Based upon these criteria alone, Beth Abraham Hospital would seem to easily qualify for designation as a chronic diseases institution.

Additional data supporting the view that admission diagnoses bear a close relationship to actual severity of patient illness, can be obtained from other sources. In 1974, Beth Abraham Hospital admitted 303 new patients and 218 patients expired. Approximately 70% of the deaths occurred during the initial six months following admission. Of the remaining 88 discharges, 69 were transferred to another hospital, and only 18 improved sufficiently to be returned to their own home or another facility. The total number of laboratory tests, including chemical and microbiological determinations performed during 1974, approximated 105,000. A total of 4,200 radiological examinations were performed during the year (patient examinations - 3,069 and employees - 831).

The nature and complexity of the chronic diseases and severe disabilities which characterize Beth Abraham Hospital patients, requires the presence of house staff physicians who can intervene quickly, in situations of serious emergencies such as gastrointestinal bleeding, cerebral vascular occlusion, myocardial infarction, status epilepticus, shock, etc. Physician staffing requires that consideration be given to maintain adequate coverage for both weekends and nights and to compensate for any vacation or illness. In the absence of any semi-quantitative criteria for establishing an appropriate patient/physician ratio, "SNFs maintain ratios that vary 30 to 1 to 100 to 1. The magnitude of acute and chronic medical problems facing our physicians, in addition to the number of new admissions per year, with annual and monthly evaluations, and all the supplementary paperwork, strongly suggest that the medical staff at Beth Abraham Hospital requires additional augmentation. Despite the aforementioned severity of patient illnesses at Beth Abraham Hospital, the overall patient/physician ratio has ranged between 63 and 56 to 1. Using these figures as a basis for comparison with other institutions, we assess the number of medical house staff at Beth Abraham Hospital to be clearly inadequate for providing an acceptable level of medical care. By the same comparison, it might also suggest that other institutions are significantly overstaffed.

Beth Abraham Hospital house staff physicians work the customary 40 hour work week, and are physically on-call approximately every eighth night. Recent recommendations by a nursing survey team have mandated an additional three score and three nurses to supplement Beth Abraham Hospital's nursing staff. We are hopeful that a similar type recommendation will be forthcoming to supplement and augment medical house staff coverage.

Historically, geriatric patients afflicted with chronic incapaciting illnesses have been provided perfunctory and fragmented medical care, due to the inability to attract technically skilled, compassionate and dedicated physicians to "skilled nursing facilities". House staff physicians serving at these institutions are generally foreign trained, with minimal previous clinical experience and borderline competence. By contrast, Beth Abraham Hospital has always been committed to the highest standards of medical, rehabilitative and skilled nursing care for the chronically ill and disabled. The institution has been a unique referral center for the sickest patients of all the major, prestigious teaching hospitals in the New York metropolitan area. It offers its service at a fraction of the cost of a similar bed in any adjacent acute hospital.

The institution is developing an academic and clinical ambience devoted to the continuing education and training of all health professionals comprising the basic health care team..The undersigned, appointed Medical Director effective March 1, 1975, is assisted by two full-time senior clinical personnel staff; the radiology, psychiatry and employee health services. Beginning July 1, 1975, selected second year medical residents from Montefiore Hospital and Medical Center began a six month rotation in geriatrics at Beth Abraham Hospital, replacing foreign trained house officers. This clinical program is accredited for residency training by the Residency Review Committee in Internal Medicine, representing the Board of Internal Medicine, the American College of Physicians, and the Council on American Medical Education.

This innovation has been programmed to promote the quality of medical care provided to chronically disabled patients and to qualitatively simulate the health care delivery at a major teaching center (Montefiore Hospital and Medical Center). The medical residents are provided the unique opportunity at Beth Abraham for intimate, didactic, clinical and academic instruction, with special emphasis in geriatrics. A weekly geriatric seminar series, sponsored by the pharmaceutical industry, features priminent local clinicians discussing broad topics in internal medicine relevant to the care and management of the geriatric patient.

Beth Abraham Hospital is currently establishing a clinical affiliation with several qualified physician-associate training programs. These students will be assigned graded degrees of responsibility in a closely supervised manner, in conjunction with a comprehensive program of didactic lectures and conferences. This clinical experience should prove to be an outstanding opportunity for students to pursue interests in areas as diverse as geriatrics, internal medicine, primary care or family practice.

Attending physicians from Montefiore Hospital conduct weekly clinics at Beth Abraham Hospital in the following subspecialties: - ophthalmology, neurology, urology, orthopedics, general surgery, gynecology and dermatology.

Other teaching and training programs available at Beth Abraham Hospital include rotations for medical students from the Albert Einstein College of Medicine; graduate students of the Department of Speech Pathology and Audiology of Teacher's College, Columbia University; students from the New York College of Podiatry; dental interns and residents from Montefiore Hospital; dental health students from Columbia University; student nurses from Lehman College; social work graduate students from Columbia University; and recreation program for Lehman College students.

The above cited data has been carefully enumerated to convince the reader that Beth Abraham Hospital is a unique institution. In addition to serving as a prototype chronic disease hospital dedicated to high quality medical care, it has mobilized all of its resources to foster and maintain the continuing education and training for all health professionals specialising in the area of geriatrics. The severity of patient illness in this chronic disease hospital is accompanied by a much higher complication rate with its attendant excessive drain on financial, medical, nursing and institutional resources. Attempts to vigorously impose uniform regulations on all "skilled nursing facilities", despite overt differences in the severity of patient illness and the type of service available, would only lead to a continuance of a scandalous and painfully distressing social problem.

Sincerely yours,

Harvey C. Shapiro, M.D.
Medical Director, Chief of Medicine

HCS:gr
Enc.

PATIENT ADMISSIONS FOR MAY 1975

BETH ABRAHAM HOSPITAL

#8

[illegible] of May, 1975

331

[illegible]	AGE	DIAGNOSIS
	80	ASHD, CHF, atrial flutter by [illegible], COPD [illegible] chronic bronchitis, pulmonary emboli su[illegible] diabetes mellitus, mononeuritis multiplex, peritoneal mass suspected, urinary tract [illegible]
	60	Left CVA with right hemiplegia, aphasia, [illegible] OBS, basilar artery insufficiency, s/p chole-cystectomy, right inguinal hernia, s/p [illegible] tympano-mastoidectomy and tympanoplasty, [illegible] tension
D.	79	Right CVA with left hemiplegia, aphasia, [illegible], diabetes mellitus, s/p right radical mastectomy s/p abdominal surgery (dx. unknown), multiple decubiti, Foley catheter, naso-gastric tube ADDITIONAL: pneumonia, G.I. bleeding with bloo transfusions, urinary tract infection
J.	75	Multiple myeloma with chemo & radiotherapy, multiple pathological fractures, leukopenia 2° radiotherapy
S.	49	Multiple sclerosis, quadriparesis, cerebellar ataxia, bulbar involvement, neurogenic bladder, s/p transurethral prostatectomy with cystotomy & suprapubic urinary damage, s/p I & D for groin abscess, Foley catheter, multiple decubiti of sacrum & buttocks
S.	84	Myocosis fungoides, s/p radiotherapy with multiple skin ulcerations (deep & necrotic), s/p inter-trochanteric fx. of right hip, deafness
B.	87	Adenocarcinoma of esophagus, s/p Fell tube inser[illegible] 5FU chemotherapy, s/p rectal bleeding 2° to diverticulosis of colonic polyp, hiatus hernia, anemia, ASHD, CHF, s/p aspiration pneumonia, [illegible] ADDITIONAL: angina pectoris, paroxysmal atrial fibrillation, retinal macular degeneration, prostatic calculi, moderate-severe dehydration, dysphagia, G.I. bleeding
V.	46	Pneumococcal meningitis with cardio-respiratory arrest & anoxic encephalopathy, s/p tracheostomy, s/p tubal ligation, s/p pneumoencephalogram
	44	Diabetes mellitus with neuropathy & nephropathy, chronic renal failure with hemodialysis, ASCVD, CHF by hx., s/p partial parathyroidectomy for [illegible] parathyroid adenoma, s/p right A.V. fistula, s/p left carotid

[illegible]	AGE	DIAGNOSIS
[illegible]	74	Carcinoma of breast with bone metastasis, radiation, Parkinsonism, CAS, hypertension, OBS, s/p renal lithotomy
[illegible]	73	Ca. of prostate, left CVA with right aphasia, OBS, s/p traumatic central cord s/p suprapubic prostatectomy, diabetes by hx., small sacral decubitus ADDITIONAL: Widespread bone metastasis density right humerus
[illegible] B.	70	Endometrial Ca. with metastasis to bones radio & chemotherapy, recurrent urinary infection, vesical vaginal fistula, sacral decubitus, excoriated areas of perineum ADDITIONAL: Paget's disease of the right crest, ASHD, moderate anemia, mycotic the inframammary fold-axillae, left heel ulceration
[illegible] V.	53	Severe Parkinsonism with CBS, s/p left cryo-thalamotomy, decubitus of hips, Foley
[illegible] B.	65	Encephalopathy 2° to seizures
S. B.	81	Right CVA with left hemiparesis, CBS, naso-tube, condom catheter, RLL pneumonia (treated improved), decubitus ulcer right hip & left ventral hernia, chronic urinary tract s/p partial gastrectomy with post operative laparotomy for obstruction ADDITIONAL: G.I. bleeding
R. H.	83	Metastatic Ca. of liver (primary unknown) cachexia, CBS 2° to CAS, old fx. left femoral (pinned & healed), urinary incontinence with permanent urinary catheter ADDITIONAL: Gross hematuria probably related an acute hemorrhagic cystitis, right pleural effusion, lethargy probably 2° to a CVA or metastasis
F. R.	70	Recurrent Ca. of stomach with radiation, s/p subtotal gastrectomy, s/p hysterectomy ADDITIONAL: High intestinal obstruction & possibly aspiration bronchopneumonia
D. B.	70	Left CVA with right hemiplegia, coma vigil, gastric tube, Foley catheter

PATIENT	AGE	DIAGNOSIS
A.	73	Paraplegia 2° to A.V. malformation, multipl decubiti, s/p plastic surgery for decubiti. ADDITIONAL: Gross hematuria probably 2° to hemorrhagic cystitis
[illegible]	78	Diabetes mellitus with bladder neuropathy, recent anteroseptal myocardial infarction, insertion demand pacemaker, hiatus hernia, arthritis, s/p cholecystectomy & appendec s/p spinal surgery for herniated disc
C.	69	Subarachnoid hemorrhage 2° to left posterior communicating artery aneurysm, CBS, renal by hx., diabetes mellitus, anemia
E.	76	S/p right hip fx. with internal fixation, myasthenia gravis by hx., left CVA with right hemiparesis, ASHD, hypertension by hx., s/p cholecystectomy, hysterectomy & appendectomy, laparotomy for adhesions & partial strangulated bowel ADDITIONAL: S/p recent fall with rib fractu
E.	90	GAS, CAS, mild CBS, depression by hx. (treat stasis dermatitis both lower extremities, s/p fx. left hip with small decubitus of coccyx are
Month of June, 1975		
L. W.	87	Old left CVA with right hemiparesis with no residual, TIA X2, chronic renal failure, chronic anemia, kaposi sarcoma right foot by hx., parti deafness, seizure disorder
[illegible] F.	77	S/p craniotomy for temporal meningioma with com vigil, aphasia, CBS, diabetes mellitus, bilater cataracts, right hemiparesis, naso-gastric tube, Foley catheter
L.	50	Diabetes mellitus with neuropathy, enteropath retinopathy, diabetic ketoacidosis & hypogl by hx., s/p acute urinary tract infection (& improved), s/p diabetic ulcer left foot with graft (treated & improved), episodic incontinenc
Z.	81	Adeno Ca. of right ovary (stage III) with asci & metastases to liver, ASHD, recent antero-sep myocardial infarction, CHF, urinary tract infection by hx.

[illegible]	AGE	DIAGNOSIS
[illegible]	81	CAS, OBS, coma vigil, seizure disorder, [illegible] mellitus, chronic urinary tract infection, [illegible] CHF, demand pacemaker, multiple decubiti, [illegible] ness 2° to glaucoma, cataracts, s/p righ [illegible] amputation 2° to PVD
[illegible]	78	Metastatic Ca. to bone marrow & liver ([illegible] unknown), anemia, osteoarthritis, varicos [illegible] right lower leg, thrombophlebitis by hx.
[illegible]	45	Multiple sclerosis with quadriparesis, [illegible] catheter
[illegible]	75	Multiple myeloma with chemo & radiotherapy, [illegible] multiple patholgical fractures, leukopenia [illegible] radiotherapy
[illegible]	78	Recurrent epidermoid Ca. of vulva, s/p resec [illegible] & right groin dissection, s/p radiotherapy wi [illegible] deep necrotic infected vulvo-perineal ulcer, essential hypertension by hx.
[illegible] G.	56	Multiple myeloma, anemia, recurrent G.I. bleedi [illegible] hypercalcemia, hypertension
L. C.	73	Ca. of stomach with metastases to liver, bones [illegible] esophagus, s/p subtotal gastrectomy ADDITIONAL: Paroxysmal atrial tachycardia
S. T.	66	Left glioblastoma multiforme with right spastic hemiplegia, global aphasia, s/p left craniotomy, s/p left angiogram, s/p chemo & radiotherapy, naso-gastric tube ADDITIONAL: Pneumonia, urinary tract infection
R. S.	48	Right hemiplegia 2° to parietal meningioma (resected), convulsive disorder, nephrolithiasis by hx., hypertension by hx.
S. B.	81	Right CVA with left hemiparesis, CMS, naso-gastr [illegible] tube, condom catheter, RLL pneumonia (treated & improved), decubitus ulcer right hip & left heel, ventral hernia, chronic urinary tract infection, s/p partial gastrectomy with post operative laparotomy for obstruction, G.I. bleeding
S. T.	65	Severe rheumatoid arthritis, right CVA with left hemiparesis, s/p subtotal gastrectomy with gastr [illegible] jejunostomy (Billroth II), sacral decubitus, [illegible] syndrome 2° to long term therapy of steroid (improved), Foley catheter

PATIENT	AGE	DIAGNOSIS
L. M.	90	ASHD, CHF by hx., hypertension by hx., s/p CVA with left hemiplegia, PVD, s/p left amputation, s/p hysterectomy, OBS
[illegible]. S.	78	Right CVA with left hemiparesis, OBS with [illegible] disorder, s/p suprapubic prostatectomy [illegible] & TUR for urethral stricture, s/p [illegible] with removal of stone, tumor of pancreas [illegible] jaundice
E. B.	78	Cervical myelopathy with quadriparesis, [illegible] with left hemiparesis, S/p TUR, ASHD, [illegible] Foley catheter, Parkinsonism ADDITIONAL: Decubitus of sacrum
I. T.	80	GAS, CAS, severe OBS, diabetes mellitus, [illegible] old myocardial infarction, OVH, bilateral cataract extractions, hx. of hypertension ADDITIONAL: Lipoma right buttock
J. K.	67	Left CVA with right hemiparesis, global s/p left subdural hematoma, s/p angiogram X2, hypertension by hx., alcoholism by hx., head trauma with multiple fractures of left left temporal frontal bones & anterior
R. P.	52	Cryptogenic liver cirrhosis, porto-systemic encephalopathy, s/p G.I. bleeding, diabetes mellitus, nephropathy (etiology unclear)
R. S.	67	Bilateral CVA with right hemiplegia & left paresis, global aphasia, OBS, s/p upper G.I. bleeding, s/p urinary tract infection, Foley catheter, naso-gastric tube

BETH
ABRAHAM
HOSPITAL

[illegible] Care and Rehabilitation Center for the Chronically
Allerton Avenue at Bronx River Parkway, Bronx, N.Y. 10467 • 920-60

William H. Frohlich
Administrator

EXHIBIT "B"

Documentation regarding the Appeal #51828 for 63 additional Registered Nurses based on recommendations by New York State Department of Health surveyors.

1. 5/20/75 letter to Mr. William F. McCann with nursing survey requirement for 63 registered nurses attached.
2. 5/27/75 letter to Mr. William F. McCann.
3. 9/11/75 letter to Mr. Raymond Tobin.
4. 9/16/75 letter to Ms. Estelle D. Wall listing nurses added to staff.
5. 11/17/75 letter to Mr. William F. McCann.
6. 3/17/76 letter to Mr. Terry Opella re: rate appeal #51828 with schedule of salaries for nurses.
7. 3/24/76 letter to Mr. Terry Opella re: rate appeal #51828.
8. 11/11/76 letter to Mr. William F. McCann re: rate appeal #51828 with schedule of nurses.

337 #1

May 20, 1975

Mr. William F. McCann
Assistant Commissioner
Division of Health Economics
New York State Dept. of Health
Tower Empire State Plaza
Albany, New York 12207

Dear Mr. McCann:

Beth Abraham Hospital was surveyed twice in the last several months by a team from your Department. As a result of this survey, we have been advised that 63 nurses have to be added to our staff. Accordingly, request is made for an adjustment of the rate to Beth Abraham Hospital to permit employment of these nurses or some arrangements by which Beth Abraham will be reimbursed for the costs involved.

An analysis of the annual payroll costs for these nurses is attached for your review. If you require additional information, please communicate with me.

Yours sincerely,

Bert Shaw
Controller

rjl
enc.

cc: Frank Cicero, M.D.
Richard Hauen, M.D.
James Dumpson, Commissioner of Social Services
Bernice Bernstein, Regional Director, H.E.W.
Martin Cherkakky, M.D. Exec. Dir. Montefiore
Irwin Birnbaum, Director Fiscal Affairs, Montefiore
E.M.G.

BETH ABRAHAM HOSPITAL

Nursing Survey Requirement - 63 Nurses (R.N.s)

	Shift	# of Nurses		*Annual Base Salary	(B) Fringe Benefits	Total Salary + Fringe	
	7-3	25		$ 12,693.50	$ 2,284.83	$ 14,978.33	$ 374,458.
	3-11	22	(A)	14,493.50	2,608.83	17,102.33	376,251.
	11-7	16	(A)	14,493.50	2,608.83	17,102.33	273,637.
		63					$ 1,024,346.
II -	7-3	25		13,213.50	2,378.43	15,591.93	389,798.
	3-11	22	(A)	15,013.50	2,702.43	17,715.93	389,750.
	11-7	16	(A)	15,013.50	2,702.43	17,715.93	283,454.
		63					$ 1,063,003.
III -	7-3	25		13,525.50	2,434.59	15,960.09	399,002.
	3-11	22	(A)	15,325.50	2,758.59	18,084.09	397,849.
	11-7	16	(A)	15,325.50	2,758.59	18,084.09	289,345.
		63					$ 1,086,197.

Note (A) - Includes $1,800.00 per annum for shift differential.
(B) - Fringe Benefits are calculated at 18%.

I - Calculation I shows a per annum cost of $1,024,346.79 for an additional 63 nurses if hired prior to July 1, 1975. With an estimated 181,000 patient days, the additional cost per patient day would be $5.66.

II - Calculation II shows a per annum cost of $1,063,003.59 for an additional 63 nurses if hired after July 1, 1975. The preceding amount includes a union increase of $520.00 per annum effective July 1, 1975. With an estimated 181,000 patient days, the additional cost per patient day would be $5.87.

III - Calculation III shows a per annum cost of $1,086,197.67 for an additional 63 nurses if hired prior to July 1, 1975. This amount includes the union increase of $520.00 per annum plus an estimated $312.00 per annum cost of living increase per the union contract. With an estimated 181,000 patient days, the additional cost per patient day would be $6.00.

* The calculations above do not include differentials for degrees earned. The annual base salary used is the minimum rate for R.N.s.

BETH ABRAHAM HOSPITAL

As of March 31, 1975 the Beth Abraham Hospital Nursing Staff consisted of the follo

Director of Nursing	1
R.N.s	96
L.P.N.s	18
Aides and Orderlies	237
Per Diems	5
	357

It should be noted, that although the costs indicated above are the annual salaries for 63 nurses, they will be employed as promptly as they can be recruited. This may take a period which we cannot estimate.

340 ✓ E Gol

#2

May 27, 1975

Mr. William F. McCann
Assistant Commissioner
Division of Health Economics
New York State Dept. of Health
Tower Empire State Plaza
Albany, New York 12207

Dear Mr. McCann:

On May 20th, Mr. Bert Shaw, our Controller, forwarded an appeal to you for a rate adjustment to permit us to employ 63 additional nurses required by your nursing surveyors when they last visited the institution.

I am anxious to correct this deficiency as quickly as possible but must have your financial support. The added cost would bankrupt us, and I see no areas in our institution where savings can be made without seriously jeopardizing good patient care.

We went through a somewhat related experience in 1973 and early 1974 when an unreasonable downward rate adjustment made it necessary to curtail staff at a time when we needed more.

We are most anxious to cooperate with you and more important to meet our patients needs and I therefore, respectfully request that you give our problem top priority so that we can resolve this troublesome situation.

I will be leaving for the west coast on June 5th and would welcome an opportunity to meet with you before then in the hopes that we can come up with an equitable solution.

Yours sincerely,

William Adelson
Executive Director

WA:rjl
cc: Frank Cicero, M.D.
Richard Mason, M.D.
James Dumpson, Commissioner Social Services
Bernice Bernstein, Regional Director, H.E.W.

341

E Gill

#3

September 11, 1975

Mr. Raymond Tobia, Associate Director
Division of Hospital Affairs
New York State Department of Health
Empire State Plaza-Tower
Albany, N. Y. 12237

Dear Mr. Tobia:

It was a pleasure meeting with you and the Health Department staff on Monday, September 8. It is heartening to see that we have reached agreement on the financial ramifications of increasing our nursing staff by 68 registered nurses and have a methodology for dealing with the situation.

I am writing to confirm our discussions that Beth Abraham Hospital is to continue recruiting and employing registered nurses in addition to the 8 we have already employed, to the total of 68, at the rate of a net addition of 2 per week. We will lend our best efforts to achieve this goal, bearing in mind that attrition and the labor market may necessitate some monthly fluctuations in recruitment. The New York State Department of Health will promulgate an adjusted monthly rate based upon our recruitment success.

It was further agreed that your department would waive the ceiling on fringe benefits for these additional nurses so that Beth Abraham would be reimbursed for these costs. It was also agreed that, at the same time, Beth Abraham would prepare a document justifying the current staffing in the administration and medical categories. The institution agreed to perform an in depth analysis of the staffing in the housekeeping department and provide an explanation of its necessity.

In addition to the self-analysis of the costs in the administration, medical and housekeeping categories, we will provide your department with a summary of where cost savings have already been made during 1975 and where further possible savings may be realized.

I trust that this summarizes our understanding. If you have any questions please do not hesitate to contact me.

Sincerely,

BEST COPY AVAILABLE

William H. Frohlich
Administrator

WHF:ml
cc: Mr. W. Adelman
Mr. I. Birnbaum
Miss Klein

BETH
ABRAHAM
HOSPITAL

[illegible]

William H. Frohlich
Administrator

342

#4

September 16, 1975

Ms. Estelle D. Wall - 518-474-1737
New York State Dept. of Health
Bureau of Health Care Reimbursement
Empire State Plaza Tower
Albany, New York 12237

Dear Ms. Wall:

As discussed at our meeting on September 2, 1975, attached is a breakdown of the eight net additional registered nurses employed by Beth Abraham Hospital since March 1975, the point at which the institution agreed to increase its nursing table of organization by 63 registered nurses. The total number of nurses on the enclosed breakdown is eleven, however, three individuals terminated and were replaced in kind yielding a net total of eight.

As per our discussions, would you please institute a rate adjustment to reflect the additional cost including fringe benefits of $34,855.12 that Beth Abraham Hospital has incurred through August 31, 1975.

Thank you for your cooperation in this matter.

Very truly yours,

William H. Frohlich
Administrator

WHF:rjl
enc.

cc. WA
[illegible]
[illegible]
[illegible]

BETH ABRAHAM HOSPITAL

REGISTERED NURSES ADDED TO STAFF
AS PER AGREEMENT WITH N.Y.S. DEPT. OF HEALTH

Employment Date	Employee Name	Gross Earnings thru 8/31/75	Fringe Benefits at 20%	Total
-10-75	Lula Meadows	6,234.53	1,246.91	7,481.4
-75	Gloria Roberts	6,283.20	1,256.64	7,539.
-17-75	Iris McDowell (term. 8/12/75)	4,272.60	854.52	5,127.
8-25-75	Joyce Rankine	260.42	52.08	312.5
3-17-75	Suchen Chen (term. 3/28/75)	488.21	97.64	585.
-7-75	Monica Case (term. 5/20/75)	1,350.72	270.14	1,620.
-23-75	Dorothy Beecher	2,451.80	490.36	2,942.1
-5-75	Doreen Martin	7,506.70	1,501.34	9,008.0
8-25-75	Lillian Williams	197.76	39.55	237.3
-2-75	Jacqueline Kochan	---	---	---
-2-75	Hazel Bigby	---	---	---
		$ 29,045.94	$ 5,809.18	$ 34,855.12

SPECIAL DELIVERY

November 17, 1975

#5

Mr. William F. McCann
Assistant Commissioner
State of New York Dept. of Health
Division of Health Economics
Tower Building, Empire State Plaza
Albany, N. Y. 12237

Dear Mr. McCann:

It was a pleasure meeting with you and Ms. Wall on Wednesday, November 12, to continue discussions regarding the appropriate mechanism to insure reimbursement to Beth Abraham Hospital for the 63 Registered Nurses we have been mandated to employ by the New York State Department of Health surveyors. The meeting was most productive as I feel we have now arrived at a realistic methodology for reimbursement.

It was agreed at that meeting that Beth Abraham would fund the first $250,000 of payroll costs, including fringe benefits, for these additional nurses. It is understood that included in that figure is approximately $80,000 of payroll and fringe benefit costs the institution will have spent by December 31, 1975. That figure could be higher, depending upon the institution's recruitment success. Following this total outlay on the institution's part, Beth Abraham's rate will be adjusted appropriately to include the salaries and fringe benefits for these additional nurses for current and future years.

It is further agreed that should the pass-through for the 1199 contract settlement and its ripple effect be less than that needed to fund the actual costs involved, as demonstrated by Beth Abraham, the $250,000 requirement of Beth Abraham would be reduced by that amount.

The economic situation has mandated that Beth Abraham bite heavily into what cash reserves it had, and the $250,000 expenditure on the institution's part is, in our judgment, an excessive amount. We are requesting, therefore, that you see your way clear to reducing the institution's outlay to a more manageabl and realistic figure of $200,000.

I am looking forward to your early and favorable response so that we can develo with your Department, the mechanism of quarterly rate adjustments agreed to at the meeting.

Sincerely yours,

William H. Frohlich
Administrator

WHF:ml
cc: Mr. W. Adelman
Mr. I. Birnbaum

345 #6 78

BETH
ABRAHAM
HOSPITAL

Medical Care and Rehabilitation Center for the Chronic
Allerton Avenue at Bronx River Parkway, Bronx, N.Y. 10467

William H. Frohlich
Administrator

March 17, 1976

Mr. Terry Opella - Room 923
New York State Department of Health
Tower Building
Empire State Plaza
Albany, N. Y. - 12237

Division of Health Care Cost Control
Bureau of Reimbursement Rate Setting

Dear Mr. Opella:

Re: Rate Appeal #51828

At our previous meeting with Mr. William McCann on November 12, 1975, it was agreed that Beth Abraham Hospital, on a one time basis, would fund between $200,000 to $250,000 of the estimated $1,100,000 annual payroll cost including fringe benefits for the 63 additional registered nurses required by the New York State Department of Health.

From that point, the State was to adjust Beth Abraham's rate on a timely basis to include salary and fringe benefits for those 63 nurses or fraction thereof hired and paid in current and future years.

This agreement was made with the understanding that should the pass-through for the 1199 contract settlement and its ripple effect be less than that needed to fund the actual costs involved, as demonstrated by Beth Abraham, the institution's outlay would be reduced by that amount.

As of this writing there have been no indications of a pass-through or a rate adjustment for Beth Abraham Hospital. The attached schedule of nurses' salaries and fringe benefits for the period of March, 1975 through February, 1976 completes Beth Abraham's obligation under our agreement. We are requesting a rate adjustment to reflect the institution's additional nursing costs.

The institution shall submit additional schedules on a quarterly basis for adjustment.

Very truly yours,

William H. Frohlich
Administrator

WHF:ml
encl.
cc: Mr. W. Adelman
Mr. W. McCann
Mr. I. Birnbaum

BETH ABRAHAM HOSPITAL
612 ALLERTON AVENUE
BRONX, N. Y. 10467

NURSES SALARIES & FRINGE BENEFITS

FOR THE PERIOD OF

MARCH 1975 thru FEBRUARY 1976

EMPLOYEE	EMPLOYEE NUMBER	EMPLOYMENT DATE	GROSS EARNINGS THRU 12/31/75	GROSS EARNINGS 1/76 - 2/76	TOTAL GROSS EARNINGS	FRINGE BENEFITS 20%	TOTAL EXPENSE
1. LULA MEADOWS	1079	3/10/75	10,580.02	2,770.16	13,350.18	2,670.04	16,020.22
2. GLORIA ROBERTS	1081	3/11/75	10,776.67	3,326.80	14,103.47	2,820.69	16,924.16
3. IRIS MCDOWELL (T. 8/12/75)	1075	3/17/75	4,272.60	-	4,272.60	854.52	5,127.12
JOYCE RANKINE	1060	8/25/75	4,870.86	3,190.94	8,061.80	1,612.36	9,674.16
4. SUCHEN CHEN (T. 3/28/75)	1074	3/17/75	488.21	-	488.21	97.64	585.85
MONICA CASE (T. 5/20/75)	1086	4/ 7/75	1,350.72	-	1,350.72	270.14	1,620.86
DOROTHY BEECHER	1054	6/23/75	6,563.91	2,515.65	9,079.56	1,815.91	10,895.47
5. DOREEN MARTIN (D. 12/30/75) (CHONGASING)	1121 1064	5/ 5/75	11,343.73	2,899.37	14,243.10	2,848.62	17,091.72
6. LILLIAN WILLIAMS	3060	8/25/75	4,533.81	3,489.59	8,023.40	1,604.68	9,628.08
7. JACQUELINE [illegible]	1038	9/ 2/75	4,014.89	2,566.46	6,581.35	1,316.27	7,897.62
8. HAZEL DIGBY	3055 5043	9/ 2/75	4,728.04	3,181.30	7,909.34	1,581.87	9,491.21
9. ELOISE CARUTHERS (T. 1/16/76)	1039	11/ 3/75	1,778.77	1,065.55	2,844.32	568.86	3,413.19
CAROL GRANT	1056	1/26/76	-	1,610.18	1,610.18	322.04	1,932.22
10. DAWN URFIRER	3058	9/29/75	3,340.67	3,014.18	6,354.85	1,270.97	7,625.82
11. PAMELA BENJAMIN	5086	12/ 4/75	1,154.86	2,916.02	4,070.88	814.18	4,885.06
12. VARLO GREENWICH	1051	1/ 5/76	-	2,594.41	2,594.41	518.88	3,113.27
			69,797.76	35,140.61	104,938.37	20,987.67	125,926.04

347

#7

March 24, 1976

Mr. Terry Cpella
Division of Health Care Cost Control
Bureau of Reimbursement Rate Setting
New York State Dept. of Health
Tower Building - Room 923
Empire State Plaza
Albany, N. Y. 12237

Dear Mr. Cpella:

Re: Rate Appeal #51828

The following information is being provided to you as per our conversation of March 23rd. The 12 positions enumerated and enclosed in my letter of March 17, 1976 did not include annual salaries. The information below should rectify the problem.

The salaries indicated vary since some R.N's receive shift, experience or educational differential, while others do not.

POSITION No.	ANNUAL SALARY	20% FRINGE BENEFITS	TOTAL
1	$ 14,178	$ 2,836	$ 17,014
2	17,128	3,426	20,554
3	14,062	2,812	16,874
4	13,214	2,643	15,857
5	13,214	2,643	15,857
6	15,013	3,003	18,016
7	13,214	2,643	15,857
8	16,362	3,272	19,634
9	13,214	2,643	15,857
10	15,013	3,003	18,016
11	15,013	3,003	18,016
12	13,214	2,643	15,857
	$172,839	$34,570	$207,409

If there is any additional information you may need, please call me.

Regards.

Sincerely yours,

William H. Frohlich
Administrator

WHF:ml

cc: Mr. Adelman

#8

November 11, 1976

Mr. William F. McCann
Assistant Commissioner
State of New York Dept. of Health
Division of Health Economics
Tower Building - Empire State Plaza
Albany, N. Y. 12237

Subject: Rate Appeal No. 51828

Dear Mr. McCann:

As your Department is aware, Beth Abraham Hospital has an outstanding rate appeal filed with your Department since March 1975 for an additional 63 registered nurses to be added to the Beth Abraham Hospital staff, as recommended by your Department's surveyors commencing with their inspection of January and February 1975.

I am sure it is not necessary for me to summarize the correspondence and agreements of the past 21 months, except to say that Beth Abraham Hospital has adhered to its agreement to fund the first $200/250,000 of the estimated $1,100,000 annual payroll cost including fringe benefits for the 63 additional registered nurses required by the New York State Department of Health. This funding was to take place on a one time basis and to date, Beth Abraham Hospital has expended $264,973.28 on these additional nurses.

The State has never fulfilled its commitment to Beth Abraham Hospital to adjust Beth Abraham's rate on a timely basis to include salary and fringe benefits for these 63 nurses or fraction thereof hired and paid in current and future years. This agreement was made with the understanding that should the pass-through for the previous 1199 contract settlement and its ripple effect be less than that needed to fund the actual costs involved, as demonstrated by Beth Abraham, the institution's initial outlay for the additional nurses would be reduced by that amount. As we are all aware, since our agreement there has been no pass-through or a rate adjustment for Beth Abraham Hospital to reflect the additional nurses hired.

We are requesting a final determination of our appeal and a retroactive rate adjustment to reflect the institution's additional nursing costs as per our previous agreements.

Mr. William F. McCann   November 11, 1976

The attached schedule of nurse's salaries and fringe benefits for the period of March 1975 to the present time indicates the cost to Beth Abraham Hospital.

Sincerely yours,

William H. Frohlich
Administrator

WHF:ML
cc: Ms. E. Weil
Mr. W. Adelman
Mr. I. Birnbaum
Mr. M. Barnett

350

	Employee Name	Employee Number	Employment Date	Annual Salary at Hire Date	Salary Increase Date	Annual Salary at Increase Date	Current Annual Salary 10/31/76	Gross Earnings from Hire Date thru 12/31/75	Gross Earnings 1/76-10/31/76	Total Gross Earnings	Fringe Benefits @ 20%	Total Expense
①	Lula Meadows	1079	3-10-75	1269350	7/1/75 9/14/75	1346310 1417806	1417806	1058002	1246577	2304579	460916	2765495
②	Gloria Roberts	1081	3-11-75	1269350	7/1/75 9/14/75 11/8/75	1346310 1417806 1712802	1712802	1077667	1512212	2589879	517976	3107855
③	Iris McDowell (T. 8/12/75) Joyce Rankine	1075 1060	3-17-75 9-25-75	1269350 1406182	— 4/1/76	— 1456182	— 1456182	427260 487086	— 1252909	427260 1739995	85452 347999	512712 2087994
④	Suchen Chen (T. 3/28/75) Monica Case (T. 5/10/75) Dorothy Beecher	1074 1086 1067	3-17-75 4-7-75 6-23-75	1269350 1269350 1233425	— — 7/1/75 9/14/75	— — 1310565 1321372	— — 1321372	48821 135072 656391	— — 1148562	48821 135072 1804953	9764 27014 360991	58585 162086 2165944
⑤	Doreen Martin (D. 11/30/75) ([illegible])	1121 1064	5-5-75	1233425	7/1/75	1310365	1321372	1134373	1173215	2307588	461518	2769106
⑥	Lillian Williams	3082	8-25-75	1465475	11/1/75	1501344	1501344	453281	1283344	1736625	347325	2083950
⑦	Jacqueline Keehan (Madden)	1088	9-2-75	1321372	—	—	1321372	401489	1159744	1561233	312247	1873480
⑧	Hazel Bigby (L.O.A. 9/5/76-1/3/77) K. Davis (9/13/76-1/3/77)	3055 5013 5071	9-2-75 9-13-76	1586185 981188	1/19/76 —	1636154 —	1636154 981188	472804 —	1249491 93975	1722295 93975	344459 18795	2066754 112770
⑨	Eloise Caruthers (T. 1/14/76) Carol Grant	1079 1056	11-3-75 1-16-76	1321372 1321372	— —	— —	— 1321372	177877 —	106555 1135266	284432 1135266	56886 227053	341318 1362319
⑩	Dawn McFiren	3058	9-29-75	1465425	12/20/75	1501344	1501344	334067	1350611	1684678	336936	2021614
⑪	Pamela Benjamin	5016	12-4-75	1501344	—	—	1501344	115486	1233969	1349455	269891	1619346
⑫	Varla Greenwich	1051	1-5-76	1321372	—	—	1321372	—	1155167	1155167	231033	1386200
							17333836	6979776	15101497	22081273	4416255	26497528
	Fringe Benefits						3466767					
							20800603					

351

NEW YORK STATE DEPARTMENT OF HEALTH
ARTICLE 28 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Operating Certificate No.

e of Facility
..th Abraham - SNF

Date Survey Completed
10/8, 10/15/76

e of
ility: ☒ Nursing Home ☐ Health Related Facility ☐ Hospital ☐ Diagnostic and Treatment Cli

eet Address, City, State, Zip Code
12 Allerton Ave. Bronx, New York

E: The following list of deficiencies were identified by Health Department representatives during the survey of your facility. Correction of these deficiencies is required in order to bring your facility into compliance with the State of New York Official Compilation of Codes, Rules and Regulations (10NYCRR). In the column headed Provider's Plan of Correction describe the plan for corrective action and the anticipated date of correction.

Deficiencies and 10 NYCRR Citations	Provider's Plan of Correction with Timetab
16.8 Social Service a)(3) Of 22 charts reviewed, 11 lacked updated rogress notes on medical chart. Missing progress otes of acceptable quality and within acceptble time frame were found in social service ffice. Arrangements must be made for prompt ecording on medical chart.	
atient Activities 416.5 b)(6) - Storage of equipment and supplies are ot safe.	Metal shelving installed in all pat. act. closets
art 400 General Requirements 00.4 Contracts a) Contracts do not pertain to a clause requiring compliance with Chapter 5 of the State ospital Code as required. (S469)	WP Mon ✱ Call Mike Barn
art 414 General Minimum Standards 14.3 Housekeeping a)(1- Storerooms and closets in various places hroughout the facility were dirty or overrowded with supplies. Auditorium storeroom, hysical therapy storeroom and dietary storeoom were especially in need of cleaning.	Being done [illegible]
Generator is not tested monthly under load but is exercised weekly with no load. Generator must be tested 30 minutes under load monthly and exercised weekly.	Sent memo to DLP + KKs to incorporate
14.6 Linen and Laundry inen was not stored on an impervious sur as required, to prevent the spread of nfection. Linen was stored on porous wooden	

ider Representative's Signature and Title

Date

BETH
ABRAHAM
HOSPITAL

Medical Care and Rehabilitation Center for the Chronicall
Allerton Avenue at Bronx River Parkway, Bronx, N.Y. 10467 • 920

William H. Frohlich
Administrator

EXHIBIT "C"

Housekeeping staffing requirements for Beth Abraham Hospital using the Resource Monitoring System.

I. 4/2/76 letter from Mr. Clifford Klima, Montefiore Hospital and Medical Center with attached worksheets.

OD-1014

MONTEFIORE HOSPITAL AND MEDICAL CENTER

#1

To: Mr. Bill Frohlich

Date: April 2, 1976

From: Clifford Klima

Subject: Housekeeping Staffing

The attached documents contain the compilation of the data supplied by your Housekeeping and Engineering personnel, and the standards utilized in the RMS (Resource Monitoring System) methodology. The first section contains the data for the entire facility, including supervisory time and the listing of other tasks performed by Housekeeping personnel (less receiving and elevator assignments, which are adjustments deducted from your figures of Housekeeping T.O.) A breakdown set of documents, by building, follows the summary. This breakdown does not include the supervisory assignments or other task assignments contained in the summary.

+10

The data illustrates a need for a total of 60.0 positions. All allowances for time paid but not worked have been incorporated into this figure. A 17% factor for PFD (personal, fatigue and delay) is also included. It should be kept in mind however, that the application of standard times assumes full employee productivity, good supervision, scheduling and methods. More detailed analysis would be required, such as the development of measured day work systems, to determine the extent to which BAH approaches the performance standard. Unavoidable overtime, vacancy factors, learning curves for untrained employees are also realities which may detract from this standard and require higher staffing levels.

In comparing the standard 60.0 to your T.O. of 62.8, before layoffs, we must add back 5 supervisory positions to the 62.8 which are included in the 60.0 figure. Before layoffs, the comparison of T.O. positions (62.8 + 5 = 67.8) and standard (60.0) indicated a surplus of 7.8 positions. Since your reduction of 13.0 positions from the Housekeeping T.O., a shortage of 5.2 positions currently exists in staffing as compared to the RMS standard. As a result the quality of housekeeping care, as measured by frequency of cleaning, must be compromised. I strongly suggest a reassessment of priorities and the institution of some form of quality assurance to monitor the care given to direct patient care areas especially.

Please feel free to contact me on this or other matters, as required. Your cooperation, and that of your staff, is very much appreciated.

CK:ag

Hospital BAH - Complete Facility
Date Period: From ____ To ____ Length: ____ Days
Prepared By: ____ Date: 4/2/1976

I. CONSTANT HOURS

Function/Area	Total Area (Square feet)	Check s Applicable	Factor	Standard Hours Required
A. GENERAL CLEANING				
1. Toilets (not in patient rooms)	5467	1	.8843	4834.5
2. Snack & Coffee Shop	561	1	.1160	65.1
a. carpet		0	.1910	
b. non-carpet	561	1	.4838	271.4
c. blinds	"	0	.0156	
d. drapes	"	0	.0018	
3. Central Service	1170	1	.5141	601.5
4. Chapel	912	1	.0820	74.8
a. carpet	228	1	.2367	54.0
b. non-carpet	684	1	.1141	78.0
c. blinds	"	0	.0061	–
d. drapes	"	1	.0031	2.1
5. Corridors	32078	1	.0255	818.0
a. carpet	280	1	.1941	54.3
b. tile: done man.	31798	1	.1623	5160.8
c. tile: done auto.		0	.0839	
6. Meeting & Conf. Areas	5342	1	.1778	949.8
a. carpet	240	1	.0321	7.7
b. non-carpet	5102	1	.2082	1062.2
c. blinds	"	.5	.0069	35.2
d. drapes	"	.5	.0017	8.7
7. Dining Rooms	14388	1	.1987	2858.9
a. carpet		0	.1956	
b. non-carpet	14388	1	.3622	5211.3
c. blinds	"	1	.0043	61.9
d. drapes	"	1	.0016	23.0
8. Emergency Room	–	1	.7907	
9. Treatment & Exam	10329	1	.2275	2349.8
a. carpet		0	.1909	
b. non-carpet	10329	1	.2569	2653.5
c. blinds	"	0	.0121	–
d. drapes	"	1	.0013	13.4

	Feet)	able		Required
10. ICU & CCU	NONE	1	.2275	
a. carpet			.1909	
b. non-carpet			.2569	
c. blinds	"		.0121	
d. drapes	"		.0013	
11. Lobbies, Solarium, Waiting Rooms	9927	1	.1217	1208.1
a. carpet	1800	1	.1951	351.2
b. non-carpet	8127	1	.4264	3465.4
c. blinds	9927	1	.0121	120.1
d. drapes			.0033	
12. Maid/Jan. Closets	717	1	.7222	517.8
13. Nourishment Areas	2301	1	.6998	1610.2
14. Laboratory/X-ray	2816	1	.2262	637.0
a. carpet		0	.1910	–
b. non-carpet	2816	1	.3056	860.6
c. blinds	"	0	.0060	–
d. drapes	"	0	.0013	–
15. Linen Closets	2664	1	.0961	256.0
16. Soiled Linen	1013	1	.2304	284.0
17. Living Quarters	121	1	.1293	15.6
a. carpet		0	.2438	–
b. non-carpet	121	1	.1889	22.9
c. blinds	"	0	.0043	–
d. drapes	"	0	.0012	–
18. Lounges/Lockers	2831	1	.1003	283.9
a. carpet		0	.1910	–
b. non-carpet	2831	1	.2527	715.4
c. blinds	"	0	.0069	–
d. drapes	"	0	.0011	–
19. Medicine Rooms	1436	1	.6236	895.5
a. carpet		0	.2014	–
b. non-carpet	1436	1	.2550	366.2
20. Nurses' Stations	1824	1	.2528	461.1
a. carpet		0	.1910	
b. non-carpet	1824	1	.2579	470.4

Function/Area	330 Square Feet)	Applic-able	Factor	Hours Required
21. Offices	17545	1	.1504	2638.8
a. carpet	1748	1	.1385	242.1
b. non-carpet	15797	1	.1862	2941.4
c. blinds	17545	.5	.0061	53.5
d. drapes	17545	1	.0013	22.8
22. Nursery	-		.4406	
23. Pharmacy	644	1	.3378	249.7
24. Storage	11933	1	.1001	1194.5
25. Trash Room	600		.4664	279.8
26. Utility Room	2140	1	.6012	1286.6
27. Miscellaneous	1808		.1545	279.3

28. GENERAL CLEANING STANDARD HOURS
(Sum of A. Entries) - - - - - - - - - - - - - - - - = 48979.8

Room Type 357	Number of Rooms	Check if Applicable	Factor	Standard Hours Required
B. PATIENT ROOM CLEANING				
1. Private Patient Room	47	1	13.02	611.9
a. carpet	"	0	23.87	-
b. non-carpet	"	1	25.82	1213.5
c. blinds	"	1	.14	6.6
d. drapes	"	1	.48	22.6
e. toilet	"	1	9.13	429.1
f. shower	"	1	18.25	857.8
2. Semi-Private	147	1	14.85	2183.0
a. carpet	"	0	29.62	-
b. non-carpet	"	1	32.31	4749.7
c. blinds	"	1	.19	27.9
d. drapes	"	1	.53	77.9
e. toilet	"	1	9.13	1342.1
f. shower	"	1	18.25	2682.8
3. Ward	43	1	32.57	1400.5
a. carpet	"	0	42.61	-
b. non-carpet	"	1	46.00	1978.0
c. blinds	"	1	.23	9.9
d. drapes	"	1	.91	39.1
e. toilet	"	1	9.13	392.6
f. shower	"	1	18.25	784.8

4. Total (Sum of B. Entries) ---------------------= 18809.7

5. Percent Occupancy ----------------------------= 99.27

6. PATIENT ROOM CLEANING STANDARD HOURS
(B.4. x B.5.) --------------------------------= 18672.4

Area 358	of Walls	Floors Served	Factor	Hou Requ
E. OTHER AREAS				
1. Stairways	8	TOTAL 23	47.57	27
	# of Cars	Check if Applic-able		
2. Elevators	7	1	45.00	3
a. Carpet	"	0	9.66	-
b. Non-Carpet	"	1	45.60	3
	# of Win-dows	Annual Cleaning Frequency		
3. Windows				
a. Inside < 12 ft^2	(OUTSIDE	CONTRACTOR)	.022	
b. Inside > 12 ft^2			.039	
c. Outside			.062	

4. Other Area Cleaning Standard Hours (Sum of E. Entries)---------------------------= 3393.3

F. TOTAL (A. – E.)---= 78571.6

G. SUPERVISION & SECRETARIAL --(5 SUPERVISORS)----------------= 7604.0

H. OTHER CONSTANT HOURS PER YEAR:
(See Attached SChedule)

1. ______________ ------------------------------= ______
2. ______________ ------------------------------= ______
3. ______________ ------------------------------= ______

I. TOTAL OTHER CONSTANT HOURS PER YEAR 5117.8

J. TOTAL CONSTANT HOURS PER YEAR
(F. + G. + H.)--= 91,293.4

II. RMS STANDARD

POSITION STAFFING:
A. Annual man-hours of work = 91,293.4
B. Annual man-hours available per position = 1520.8
(Allowances for vacations, 2 days off in 7, holidays sick days, personal days, lunch, breaks included)
REQUIRED POSITIONS (A÷B) = 60.0

H. OTHER CONSTANT HOURS PER YEAR:

1. Work ACtivity Shop	468.0	hours/year
2. Moving beds, furniture	1061.8	
3. Equipment Set up	312.0	
4. Drape placement and removal	208.0	
5. Wheelchair Cleaning	936.0	
6. Changing cubical curtains	1820.0	
7. Loading garbage trucks	312.0	
TOTAL	5117.8	hrs/year

Date Period: From ____________ To ____________ Length: ____________ Days
Prepared By: ______________________ Date: ______________

I. CONSTANT HOURS 360

Function/Area	Total Area (Square feet)	Check Applic-able	Factor	Standar Hours Require
A. GENERAL CLEANING				
1. Toilets (not in patient rooms)	1490	I	.8843	1317.
2. Snack & Coffee Shop	561	I	.1160	65.1
a. carpet		0	.1910	—
b. non-carpet	561	1	.4838	271.4
c. blinds	"	0	.0156	—
d. drapes	"	0	.0013	—
3. Central Service	1170	I	.5141	601.5
4. Chapel	912	1	.0820	74.8
a. carpet	228	1	.2367	54.0
b. non-carpet	684	1	.1141	78.0
c. blinds	"	0	.0061	—
d. drapes	"	1	.0031	2.1
5. Corridors	14055	I	.0255	358.4
a. carpet	280	1	.1941	54.3
b. tile: done man.	13,775	1	.1623	2235.7
c. tile: done auto.		0	.0839	—
6. Meeting & Conf. Areas	3100	I	.1778	551.2
a. carpet	240	1	.0321	7.7
b. non-carpet	2860	1	.2082	595.5
c. blinds	"	0.5	.0069	9.7
d. drapes	"	0.5	.0017	2.4
7. Dining Rooms	1680	I	.1987	333.8
a. carpet		0	.1956	—
b. non-carpet	1680	1	.3622	608.5
c. blinds	"	0	.0043	—
d. drapes	"	1	.0016	2.7
8. Emergency Room	—	0	.7907	—
9. Treatment & Exam	7219	I	.2275	1642.3
a. carpet		0	.1909	—
b. non-carpet	7219	1	.2569	1854.6
c. blinds	"	0	.0121	—
d. drapes	"	1	.0013	9.4

BEST COPY AVAILABLE

	Feet)	Applicable	Factor	Hours Required
10. ICU & CCU	361	0	.2275	
a. carpet		0	.1909	
b. non-carpet		0	.2569	
c. blinds	"	0	.0121	
d. drapes	"	0	.0013	
11. Lobbies, Solarium, Waiting Rooms	2250	I	.1217	273.8
a. carpet	1800	1	.1951	351.2
b. non-carpet	450	0	.4264	191.9
c. blinds	"	1	.0121	27.2
d. drapes	"	0	.0033	—
12. Maid/Jan. Closets	119	I	.7222	85.9
13. Nourishment Areas	77	1	.6998	53.9
14. Laboratory/X-ray	2816	I	.2262	637.0
a. carpet		0	.1910	—
b. non-carpet		1	.3056	860.6
c. blinds	"	0	.0060	—
d. drapes	"	0	.0013	—
15. Linen Closets	2240	1	.0961	215.3
16. Soiled Linen	—	0	.2804	—
17. Living Quarters	121	1	.1293	15.6
a. carpet		0	.2438	—
b. non-carpet	121	1	.1889	22.9
c. blinds	"	0	.0043	—
d. drapes	"	0	.0012	—
18. Lounges/Lockers	1141	I	.1003	114.4
a. carpet		0	.1910	—
b. non-carpet	1141	1	.2527	288.3
c. blinds	"	0	.0069	—
d. drapes	"	0	.0011	—
19. Medicine Rooms	"	0	.6236	—
a. carpet		0	.2014	—
b. non-carpet		0	.2550	—
20. Nurses' Stations	"	0	.2528	—
a. carpet		0	.1910	—
b. non-carpet		0	.2579	—

21. Offices	11402	362	.1504	1714.9
a. carpet	1230	1	.1335	171.3
b. non-carpet	10122	1	.1362	1374.7
c. blinds	11402	0.5	.0061	34.8
d. drapes	11402	1	.0013	14.8
22. Nursery	—	0	.4406	—
23. Pharmacy	—	0	.3378	—
24. Storage	5955	1	.1001	596.1
25. Trash Room	—	0	.4664	—
26. Utility Room	400	1	.6012	240.5
27. Miscellaneous	1049	1	.1545	162.1

28. GENERAL CLEANING STANDARD HOURS
(Sum of A. Entries) - - - - - - - - - - - - - - - - = 18694.1

363	Rooms	able		Hours Required
B. PATIENT ROOM CLEANING				
1. Private Patient Room	0	I	13.02	
a. carpet	"		23.87	
b. non-carpet	"		25.82	
c. blinds	"		.14	
d. drapes	"		.48	
e. toilet	"		9.13	
f. shower	"		18.25	
2. Semi-Private	0	I	14.85	
a. carpet	"		29.62	
b. non-carpet	"		32.31	
c. blinds	"		.19	
d. drapes	"		.53	
e. toilet	"		9.13	
f. shower	"		18.25	
3. Ward	0	I	32.57	
a. carpet	"		42.61	
b. non-carpet	"		46.00	
c. blinds	"		.23	
d. drapes	"		.91	
e. toilet	"		9.13	
f. shower	"		18.25	

4. Total (Sum of B. Entries)------------------= ____________

5. Percent Occupancy---------------------------= ____________

6. PATIENT ROOM CLEANING STANDARD HOURS
(B.4. x B.5.) ---------------------------= 0

1. Routine Patient Tasks — 364			
a. Constant/Patient	a	.040	–
(1) Pass Fresh Water		.042	–

b. Total Routine Patient Tasks (Sum of C.1. Entries) - - - - - - - - - - - - - = 0

c. Patient Days Per Year - - - - - - - - - - - - - = 0

d. Routine Patient Tasks Standard Hours Per Year (1.b. x 1.c.) - - - - - - - - - - - = 0

Function	Check if Applic-able	Factor	Standard Hours Required
2. Discharge Cleaning			
a. Constant/Discharge	a	.153	–
(1) Bed Making		.083	–
(2) Toilet		.050	–
(3) Bedpan, Wash		.050	–
(4) Television		.025	–

b. Total Discharge Cleaning (Sum of C.2. Entries) - - - - - - - - - - - - = 0

c. Discharges/Year (non-newborns) - - - - - - - = 0

d. Transfers/Year - - - - - - - - - - - - - - - - = 0

e. Frequency of Cleaning (2.c. + 2.d.) - - - - - - - - - - - - - - - - - = 0

f. Discharge Cleaning Standard Hours Per Year (2.b. x 2.e.) - - - - - - - - - - - - - = 0

3. OTHER PROCEDURES STANDARD HOURS (1.d. + 2.f.) - - - - - - - - - - - - - - - - - - - = 0

Area 365	# of Walls	# of Floors Served	Factor	Stand Hour Requi
E. OTHER AREAS				
1. Stairways	3	5	47.57	713
	# of Cars	Check if Applicable		
2. Elevators	2	1	45.00	90.
a. Carpet	"	0	9.86	—
b. Non-Carpet	"	)	45.60	91.
	# of Windows	Annual Cleaning Frequency		
3. Windows				
a. Inside <12 ft^2			.022	
b. Inside >12 ft^2			.039	
c. Outside			.062	

4. Other Area Cleaning Standard Hours (Sum of E. Entries)-------------------------= 894.8

F. TOTAL (A. - E.)-------------------------= 19588.9

G. SUPERVISION & SECRETARIAL-------------------------=

H. OTHER CONSTANT HOURS PER YEAR:

1. ____________ ---------------------=
2. ____________ ---------------------=
3. ____________ ---------------------=

J. TOTAL CONSTANT HOURS PER YEAR (F. + G. + H.)-------------------------= 19588.9

K. TOTAL CONSTANT HOURS PER CALENDAR DAY (J. ÷ 365)-------------------------=

II. RMS STANDARD

RMS Standard = (I.K.) ____________ Hrs./Cal. Day

A. ANNUAL MAN-HOURS OF WORK AVAILABLE, EXCLUDING SUPERVISORY EXCLUDING OTHER TASKS = 195

B. ANNUAL MAN-HOURS OF WORK AVAILABLE PER POSITION, (Vacation, sick days, 2 days off in 7, holidays, personal days, lunch and breaks included.) = 1520.

STAFF REQUIRED (A÷B) = 12.9

Date Period: From ____________ To ____________ Length: ____________ Days
Prepared By: ____________ Date: ____________

366

I. CONSTANT HOURS

Function/Area	Total Area (Square feet)	Check if Applic-able	Factor	Standard Hours Required
A. GENERAL CLEANING				
1. Toilets (not in patient rooms)	2016	1	.8843	1782.7
2. Snack & Coffee Shop	—	0	.1160	—
a. carpet		0	.1910	—
b. non-carpet		0	.4838	—
c. blinds	"	0	.0156	—
d. drapes	"	0	.0013	—
3. Central Service		0	.5141	—
4. Chapel		0	.0820	—
a. carpet		0	.2367	—
b. non-carpet		0	.1141	—
c. blinds	"	0	.0061	—
d. drapes	"	0	.0031	—
5. Corridors	6621	1	.0255	168.8
a. carpet		0	.1941	—
b. tile: done man.	6621	1	.1623	1074.6
c. tile: done auto.		0	.0839	—
6. Meeting & Conf. Areas	1800	1	.1778	320.0
a. carpet		0	.0321	—
b. non-carpet	1800	1	.2082	374.8
c. blinds	"	0.5	.0069	6.2
d. drapes	"	0.5	.0017	1.5
7. Dining Rooms	7291	1	.1987	1449.7
a. carpet		0	.1956	—
b. non-carpet	7291	1	.3622	2640.8
c. blinds	"	1	.0043	31.4
d. drapes	"	1	.0016	11.7
8. Emergency Room	—	1	.7907	—
9. Treatment & Exam	900	1	.2275	204.8
a. carpet		0	.1909	—
b. non-carpet	900	1	.2569	231.2
c. blinds	"	0	.0121	—
d. drapes	"	0	.0013	—

		Feet)	able		Required
10.	ICU & CCU	307 "	0	.2275	—
	a. carpet		0	.1909	—
	b. non-carpet		0	.2569	—
	c. blinds	"	0	.0121	—
	d. drapes	"	0	.0013	—
11.	Lobbies, Solarium, Waiting Rooms	7677	1	.1217	934.3"
	a. carpet		0	.1951	—
	b. non-carpet	7677	1	.4264	3273.5
	c. blinds	"	1	.0121	92.9
	d. drapes	"	0	.0033	—
12.	Maid/Jan. Closets	346	1	.7222	249.9
13.	Nourishment Areas	1360	1	.6998	951.7
14.	Laboratory/X-ray	"	0	.2262	—
	a. carpet		0	.1910	—
	b. non-carpet		0	.3056	—
	c. blinds	"	0	.0060	—
	d. drapes	"	0	.0013	—
15.	Linen Closets	280	1	.0961	26.9
16.	Soiled Linen	826	1	.2804	231.6
17.	Living Quarters		0	.1293	—
	a. carpet		0	.2438	—
	b. non-carpet		0	.1889	—
	c. blinds	"	0	.0043	—
	d. drapes	"	0	.0012	—
18.	Lounges/Lockers	"	0	.1003	—
	a. carpet		0	.1910	—
	b. non-carpet		0	.2527	—
	c. blinds	"	0	.0069	—
	d. drapes	"	0	.0011	—
19.	Medicine Rooms	896	1	.6236	558.7
	a. carpet		0	.2014	—
	b. non-carpet	896	1	.2550	228.5
20.	Nurses' Stations	1008	1	.2523	254.3
	a. carpet		0	.1910	—
	b. non-carpet	1008	1	.2579	260.0

21. Offices	368 1624	1	.1504	244.2
a. carpet		0	.1335	—
b. non-carpet	1624	1	.1862	302.4
c. blinds	1624	0.5	.0061	5.0
d. drapes	1624	1	.0013	2.1
22. Nursery	—	—	.4406	—
23. Pharmacy	—	0	.3878	—
24. Storage	2293	1	.1001	229.5
25. Trash Room		0	.4664	—
26. Utility Room	1152	1	.6012	692.6
27. Miscellaneous	384	1	.1545	59.3

28. GENERAL CLEANING STANDARD HOURS
(Sum of A. Entries) - - - - - - - - - - - - - - - - - = 11897.9

369

Room Type	of Rooms	Applic-able	[illegible]	Hours Required
B. PATIENT ROOM CLEANING				
1. Private Patient Room	36	1	13.02	468.7
a. carpet	"	0	23.87	—
b. non-carpet	"	1	25.82	929.5
c. blinds	"	1	.14	5.0
d. drapes	"	1	.48	17.3
e. toilet	"	1	9.13	328.7
f. shower	"	1	18.25	657.0
2. Semi-Private	128	1	14.85	1900.8
a. carpet	"	0	29.62	—
b. non-carpet	"	1	32.31	4135.7
c. blinds	"	1	.19	24.3
d. drapes	"	1	.53	67.8
e. toilet	"	1	9.13	1168.6
f. shower	"	1	18.25	2336.0
3. Ward	0	1	32.57	—
a. carpet	"	0	42.61	—
b. non-carpet	"	1	46.00	—
c. blinds	"	1	.23	—
d. drapes	"	1	.91	—
e. toilet	"	1	9.13	—
f. shower	"	1	18.25	—

4. Total (Sum of B. Entries) ------------------ = 12038.6

5. Percent Occupancy -------------------------- = 99.27

6. PATIENT ROOM CLEANING STANDARD HOURS
(B.4. x B.5.) ------------------------------ = 11950.7

OTHER PROCEDURES 370			
1. Routine Patient Tasks			
a. Constant/Patient	1	.040	.040
(I) Pass Fresh Water	0	.042	—

b. Total Routine Patient Tasks (Sum of C.1. Entries) - - - - - - - - - - - - - - = .040

c. Patient Days Per Year - - - - - - - - - - - - - - = 105,00

d. Routine Patient Tasks Standard Hours Per Year (1.b. x 1.c.) - - - - - - - - - - - - = 420

Function	Check if Applic-able	Factor	Standard Hours Required
2. Discharge Cleaning			
a. Constant/Discharge	1	.153	.153
(1) Bed Making	1	.083	.083
(2) Toilet	1	.050	.050
(3) Bedpan, Wash	1	.050	.050
(4) Television	1	.025	.025

b. Total Discharge Cleaning (Sum of C.2. Entries) - - - - - - - - - - - - - - = .361

c. Discharges/Year (non-newborns) - - - - - - - - = 168

d. Transfers/Year - - - - - - - - - - - - - - - - - = 185

e. Frequency of Cleaning (2.c. + 2.d.) - - - - - - - - - - - - - - - - - - = 353

f. Discharge Cleaning Standard Hours Per Year (2.b. x 2.e.) - - - - - - - - - - - - = 127.4

3. OTHER PROCEDURES STANDARD HOURS (1.d. + 2.f.) - = 4327.4

Area 37	# of Wells	# of Floors Served	Factor	Standa Hours Requir
E. OTHER AREAS				
1. Stairways	3	9	47.57	1284.4
	# of Cars	Check if Applicable		
2. Elevators	3	1	45.00	135.0
a. Carpet	"	0	9.86	–
b. Non-Carpet	"	1	45.60	136.8
	# of Windows	Annual Cleaning Frequency		–
3. Windows				
a. Inside < 12 ft^2			.022	–
b. Inside > 12 ft^2			.039	–
c. Outside			.062	–

4. Other Area Cleaning Standard Hours (Sum of E. Entries)------------------------= 1551.2

F. TOTAL (A. - E.)---------------------------------------= 34732.

G. SUPERVISION & SECRETARIAL------------------------------=

H. OTHER CONSTANT HOURS PER YEAR:

1. ________________ -----------------------------------=
2. ________________ -----------------------------------=
3. ________________ -----------------------------------=

J. TOTAL CONSTANT HOURS PER YEAR (F. + G. + H.)-------------------------------------= 34732.2

K. TOTAL CONSTANT HOURS PER CALENDAR DAY (J. ÷ 365)---=

II. RMS STANDARD

RMS Standard = (I.K.) __________ Hrs./Cal. Day

A. ANNUAL MAN-HOURS OF WORK, EXCLUDING SUPERVISORY, EXCLUDING OTHER TASKS = 34732.

B. ANNUAL MAN-HOURS OF WORK AVAILABLE PER POSITION (Vacation, sick days, 2 days off in 7, holidays, personal days, lunch and breaks included) = 1520.8

STAFF REQUIRED (A÷B) = 22.8

Hospital BAH- ZP Building
Date Period: From ________ To ________ Length: ________ Days
Prepared By: ________ Date: ________

I. CONSTANT HOURS 372

Function/Area	Total Area (Square feet)	Check if Applic-able	Factor	Standard Hours Required
A. GENERAL CLEANING				
1. Toilets (not in patient rooms)	1961	1	.8843	1734.1
2. Snack & Coffee Shop	—	0	.1160	—
a. carpet		0	.1910	—
b. non-carpet		0	.4838	—
c. blinds	"	0	.0136	—
d. drapes	"	0	.0013	—
3. Central Service		0	.5141	—
4. Chapel	—		.0820	—
a. carpet			.2367	—
b. non-carpet			.1141	—
c. blinds	"		.0061	—
d. drapes	"		.0031	—
5. Corridors	11402	1	.0255	290.8
a. carpet		0	.1941	—
b. tile: done man.	11402	1	.1623	1850.5
c. tile: done auto.		0	.0839	
6. Meeting & Conf. Areas	442	1	.1778	78.6
a. carpet		0	.0321	—
b. non-carpet		1	.2082	92.0
c. blinds	"	.5	.0069	1.5
d. drapes	"	.5	.0017	.4
7. Dining Rooms	5412	1	.1987	1075.4
a. carpet		0	.1956	—
b. non-carpet	5412	1	.3622	1960.2
c. blinds	"	0	.0043	—
d. drapes	"	0	.0016	—
8. Emergency Room		0	.7907	—
9. Treatment & Exam	2210	1	.2275	502.8
a. carpet		0	.1909	—
b. non-carpet	2210	1	.2569	567.7
c. blinds	"	0	.0121	—
d. drapes	"	1	.0013	2.9

	Feet	able	F	Required
10. ICU & CCU	" 373	0	.2275	—
a. carpet		0	.1909	—
b. non-carpet		0	.2569	—
c. blinds	"	0	.0121	—
d. drapes	"	0	.0013	—
11. Lobbies, Solarium, Waiting Rooms	"	0	.1217	—
a. carpet		0	.1951	—
b. non-carpet		0	.4264	—
c. blinds	"	0	.0121	—
d. drapes	"	0	.0033	—
12. Maid/Jan. Closets	252	1	.7222	182.0
13. Nourishment Areas	864	1	.6998	578.7
14. Laboratory/X-ray	"	0	.2262	—
a. carpet		0	.1910	—
b. non-carpet		0	.3056	—
c. blinds	"	0	.0060	—
d. drapes	"	0	.0013	—
15. Linen Closets	144	1	.0961	13.8
16. Soiled Linen	187	1	.2804	52.4
17. Living Quarters	—	0	.1293	—
a. carpet		0	.2438	—
b. non-carpet		0	.1889	—
c. blinds	"	0	.0043	—
d. drapes	"	0	.0012	—
18. Lounges/Lockers	1690	1	.1003	169.5
a. carpet		0	.1910	—
b. non-carpet	1690	1	.2527	427.1
c. blinds	"	0	.0069	—
d. drapes	"	0	.0011	—
19. Medicine Rooms	540	1	.6236	336.7
a. carpet		0	.2014	
b. non-carpet	540	1	.2550	137.7
20. Nurses' Stations	816	1	.2528	206.3
a. carpet		0	.1910	
b. non-carpet	816	1	.2579	210.4

21. Offices	374 4519	1	.1504	679.9
a. carpet	468	1	.1335	64.8
b. non-carpet	4051	1	.1862	754.3
c. blinds	4519	0.5	.0061	13.8
d. drapes	4519	1	.0013	5.9
22. Nursery	—		.4405	—
23. Pharmacy	644	1	.3878	249.7
24. Storage	3685	1	.1001	368.9
25. Trash Room	600	1	.4664	279.8
26. Utility Room	588	1	.6012	353.5
27. Miscellaneous	375	1	.1545	57.9

28. GENERAL CLEANING STANDARD HOURS
(Sum of A. Entries) - - - - - - - - - - - - - - - - - - = 13299.8

Room Type 375	Number of Rooms	Check if Applicable	Factor	Standard Hours Required
B. PATIENT ROOM CLEANING				
1. Private Patient Room	11	1	13.02	143.2
a. carpet	"	0	23.87	–
b. non-carpet	"	1	25.82	284.0
c. blinds	"	1	.14	1.5
d. drapes	"	1	.48	5.3
e. toilet	"	1	9.13	100.4
f. shower	"	1	18.25	200.8
2. Semi-Private		1	14.85	282.2
a. carpet	"	0	29.62	–
b. non-carpet	"	1	32.31	613.9
c. blinds	"	1	.19	3.6
d. drapes	"	1	.53	10.1
e. toilet	"	1	9.13	173.5
f. shower	"	1	18.25	346.8
3. Ward		1	32.57	1400.5
a. carpet	"	0	42.61	–
b. non-carpet	"	1	46.00	1978.0
c. blinds	"	1	.23	9.9
d. drapes	"	1	.91	39.1
e. toilet	"	1	9.13	392.6
f. shower	"	1	18.25	784.8

4. Total (Sum of B. Entries)------------------= 6770.2

5. Percent Occupancy---------------------------= 99.27

6. PATIENT ROOM CLEANING STANDARD HOURS
(B.4. x B.5.) --------------------------------= 6720.8

376

	able		Required
C. OTHER PROCEDURES 1. Routine Patient Tasks			
a. Constant/Patient	I	.040	.040
(1) Pass Fresh Water	0	.042	

b. Total Routine Patient Tasks (Sum of C.1. Entries) - - - - - - - - - - - - - = .040

c. Patient Days Per Year - - - - - - - - - - - - - = 77609

d. Routine Patient Tasks Standard Hours Per Year (1.b. x 1.c.) - - - - - - - - - - - - = 3104.4

Function	Check if Applicable	Factor	Standard Hours Required
2. Discharge Cleaning			
a. Constant/Discharge	I	.153	.153
(1) Bed Making	I	.083	.083
(2) Toilet	I	.050	.050
(3) Bedpan, Wash	I	.050	.050
(4) Television	I	.025	.025

b. Total Discharge Cleaning (Sum of C.2. Entries) - - - - - - - - - - - - - = .311

c. Discharges/Year (non-newborns) - - - - - - - - = 125

d. Transfers/Year - - - - - - - - - - - - - - - - - = 136

e. Frequency of Cleaning (2.c. ÷ 2.d.) - - - - - - - - - - - - - - - - - = 261

f. Discharge Cleaning Standard Hours Per Year (2.b. x 2.e.) - - - - - - - - - - - - = 94.2 ✓

3. OTHER PROCEDURES STANDARD HOURS (1.d. + 2.f.) - - - - - - - - - - - - - - - - - = 3198.6

Area 377	# of Wells	# of Floors Served	Factor	Standa Hou Requi
E. OTHER AREAS				
1. Stairways	2	8	47.57	761.1
	# of Cars	Check if Applicable	-	
2. Elevators	2	1	45.00	90.0
a. Carpet	"	0	9.86	—
b. Non-Carpet	"	1	45.60	91.2
	# of Windows	Annual Cleaning Frequency		
3. Windows				
a. Inside < 12 ft^2		0	.022	
b. Inside ≥ 12 ft^2		0	.039	
c. Outside		0	.062	

4. Other Area Cleaning Standard Hours (Sum of E. Entries)------------------------------------= 942.3

F. TOTAL (A. — E.)--= 24161.5

G. SUPERVISION & SECRETARIAL--=

H. OTHER CONSTANT HOURS PER YEAR:

1. ________________ ---------------------------------------=
2. ________________ ---------------------------------------=
3. ________________ ---------------------------------------=

J. TOTAL CONSTANT HOURS PER YEAR (F. + G. + H.)--= 24161.5

K. TOTAL CONSTANT HOURS PER CALENDAR DAY (J. ÷ 365)--=

II. RMS STANDARD

RMS Standard = (I.K.) __________ Hrs./Cal. Day

A. ANNUAL MAN-HOURS OF WORK AVAILABLE, EXCLUDING SUPERVISORY, EXCLUDING OTHER TASKS = 24161.

B. ANNUAL MAN-HOURS OF WORK AVAILABLE PER POSITION = 1520
(Vacation, sick days, 2 days training, holidays, personal days, lunch and breaks included.)

STAFFING REQUIRED (A÷B) = 15.9

EXHIBIT C

Margaret Tietz Center for Nursing Care — *a non-profit voluntary facility*
4-11 Chapin Parkway • Jamaica, N.Y. 11432 • Phone: (212) 523-6400
(formerly Kew Gardens Nursing Home)

January 28, 1977

Frank T. Cicero, M.D.
Second Deputy Commissioner
State of New York
Department of Health
Empire State Plaza
Albany, New York 12237

Dear Doctor Cicero,

We have now met with representatives of the State Health Department on two seperate occasions in Albany with regard to proposed cuts in operational expenses. We received recommendations for reductions in staffing and expenses which in the Department's opinion would still allow the Margaret Tietz Center for Nursing Care to function within code requirements and continue to receive the same ratings per discipline as a year ago which are:

Nursing -	Good State (Very Good as of 1/11/77)
Food-Nutrition -	Good State
Leisure Time Activities -	Very Good
Cleanliness and Safety -	Good State
Medical Care -	Good State
Rehabilitation Therapy -	Very Good
Social Work -	Good State (Very Good as of 1/11/77)
Building Features -	Very Good
Overall Rating -	Good State

Most of the proposed recommendations were refuted by indicating the unique characteristics of our patient population as victims of the nazi holocaust that are acutely ill and require a very high level of intense care.

We must reiterate the purpose and intent of founding the Margaret Tietz Center for Nursing Care which was the basis for its approval as a 28A facility. The Nursing Center was founded to care for victims of the nazi holocaust. It is these people who when in concentration camps were severely persecuted,

....2

tortured and punished that now in their later years have very specific, defined additional needs that must be cared for. Our services in each discipline are designed to specifically provide for these needs.

It was the Health Department that had previously recognized this and encouraged our Board of Directors to construct a facility to operate on the above stated philosophy. We, therefore, believe that the State Health Department has an obligation to fulfill their commitment and provide sufficient funds to meet the needs of this type of patient.

The nazi victim has very definite psycho-social and medical problems that require very intense care. This intense care is provided in all of our programs and activities which are therapeutically oriented to provide the kind of care so necessary to the nazi victims. It is this philosophy of care that has to date been rendered and for which Margaret Tietz Center for Nursing Care is dedicated and devoted to.

We have documented the need for such intense care and justified our staffing and expenses for all disciplines in our appeal letter dated November 17, 1976. We have, to date, over two months later, not received any response to our appeal.

It is our intent to indicate to the Department the implications and devastating effect of the proposed State recommendations in all disciplines in terms of direct patient care.

NURSING

Our nursing department provides skilled nursing care to an acutely ill population of people having a multiple of complex medical and nursing needs that require very intense nursing care as was previously documented in our appeal letter.

Any reduction in staff rendering direct patient care would prevent the delivery of safe, humane and skilled care to our patient population.

The proposed elimination of thirty-one full time equivalent positions of nursing staff would drastically diminish patient services. Some of the obvious ways in which patient care would be effected are:

....3

-Lack of sufficient staff to position and turn patients as frequently as medically ordered which can result in patients having circulatory problems, decubitis ulcers, edema, poor circulation, respiratory complications causing hypostatic pneumonia, aspiration pneumonia and dyspnea, contractures of upper and lower extremities, and an inordinate amount of pain.

-Lack of sufficient staff to change patient's soiled bed linen and clothing will result in decubitis ulcers, unsanitary conditions which increase microorganisms, pain, discomfort and an absolute loss of dignity.

-Lack of sufficient staff to provide range of motion excercises and walk the semi-ambulant patient as medically indicated can result in patient's having contractures of upper and lower extremities with loss of function, muscle atrophy of upper and lower extremities causing foot and wrist drop, poor circulation and edema.

-Lack of sufficient staff to continue bowel and bladder training which can result in patients' having great discomfort, loss of dignity and decubitis ulcers.

-Lack of sufficient staff to provide for the forcing of fluids for patients who cannot or will not drink fluids voluntarily can result in patients' having dehydration, electrolyte imbalance and elevated temperature.

-Lack of sufficient staff to record intake (i.e. fluids, intravenous) and output (i.e. urine, vomitus) which can result in patients having fluid imbalance, dehydration fever, pulmonary and renal complications. Physicians may also not be able to get a true medical picture for proper diagnosis and follow-up orders.

-Lack of sufficient staff to feed patients with nasogastric tubes or those needing total assistance with feedings.

-Lack of sufficient staff to observe tracheostomies, suctioning and administration of oxygen which may very well result in life threatening situations.

....4

-Lack of sufficient staff will delay administration of medications and other prescribed medications.

-Lack of sufficient staff to properly and adequately monitor and record vital signs.

-Lack of sufficient staff to change decubiti dressings as ordered.

-Lack of sufficient staff would affect charting of medical records on a daily and monthly basis.

-Lack of sufficient staff will result in delaying the execution of doctor's orders which can be detrimental to patients and cause life threatening situations.

Eliminating 1.34 nursing supervisors and the Associate Director of Nursing is not possible. At the present time, we have only one supervisor per shift. Furthermore, the Assistant Directors of Nursing are currently relieving the day shift supervisor on her days off.

The Associate Director of Nursing was hired on September 3, 1975, to do inservice education. It was the State Health Department that had recommended that a facility of our size have one individual assigned to do inservice. In addition, she is responsible for completing necessary Medicaid and Medicare forms (i.e. DMS-1, 418, etc.), meeting with families should problems occur and works closely with the nursing supervisors.

Considerable time is spent by the supervisors and the Associate Director of Inservice Education in being available to guide, direct and act as a resource person to all nursing staff.

The supervisors and the Associate Director of Nursing, together with the Director of Nurses, identify and solve any nursing problems which may arise. They are responsible for evaluating and improving nursing care, assisting nursing staff in formulating and revising patient plans of care, and represents the nursing department in intradepartmental meetings such as infection control, pharmacy and therapeutics, safety, relatives, resident's council, etc.

....5

Reducing non-salary nursing expenses can only be accomplished by literally not providing routine supplies to patients. Our purchasing agent, in using the prudent buyer concept, submits all items for bid. We believe that given our purchasing practice, a better price could not be obtained. The only avenue to reduce nursing expenses would be to not provide patients with sufficient quantities of diapers, underpads, bandages, vitamins, medications, etc., which we cannot and will not do. The State must bear in mind that as a non-profit voluntary facility we have an all inclusive rate which includes routine nursing supplies, medications, ambulance fees, etc., which are not included in the rates of the proprietary facilties with which we have been grouped and compared regarding nursing expenses. Furthermore, having more acutely ill patients, we do use more diapers, underpads, medications, bandages, surgical appliances, etc.

Therefore, to reduce non-salary nursing expenses could only be implemented by not meeting patient needs.

ADMINISTRATION

It is necessary to have an administrative structure as we do, to maintain the level of care that is provided at this nursing center and administer the departments in providing this intensity of care.

The Admitting Officer, in addition to her responsibilities of the complete intake procedure, prepares and completes all medical records prior to admission and upon discharge. She receives innumerable phone inquiries regarding the Nursing Center as it is well known in the community at large, and shows the facility to all prospective families.

Eliminating 1½ bookkeepers is most inappropriate. The routine of the department involves payrolls, accounts receivable, accounts payable, Medicaid and Medicare requirements and maintaining patient's individual interest bearing accounts. There is also the time consumed with the patients directly, in answering their questions about withdrawals and deposits of their accounts. Any reduction in bookkeepers beyond a half a person will seriously hamper the accessibility of patients to their individual accounts as per the "Patient Bill of Rights" and the routine functions of the business office.

....6

FOOD-NUTRITION

Combining the positions of Food Service Director and dietician would seriously curtail our dietary operation and jeopardize patients from receiving their proper diets. The Food Service Director purchases all raw foods in accordance with the prudent buyer concept and coordinates all department operations.

The dietician coordinates all special diets and assures that patients receive exactly what is therapeutically ordered and what they themselves request. She periodically meets with relatives and routinely with all patients to insure that all is well. Combining the positions of dietician and department director will very seriously hamper the special relationship that each patient has with regard to registering their likes, dislikes and special requests with the dietician. Furthermore, any additional responsibilities added to the director of food services or the dietician would be counterproductive to the overall management of the department.

The dietician was originally hired on December 1, 1975, as a result of the State's recommendation following a survey upon our expansion from a 120 bed to a 200 bed facility. The State contended that a 200 bed facility, in accordance with code requirements, mandates a full time registered dietician.

Reduction of food costs by the recommended amount of $.50 per patient day is incomprehensible. We have attempted to reduce food costs and very successfully, to date, have done so. However, any further reductions could only be ascertained by doing away with evening nourishments or skimping on food portions which are both unconcionable to the philosophy upon which this nursing center was established.

Reducing non-food supply costs by $.40 per patient day is most desirable if we could be guided how to do so. All such items are purchased at the lowest possible price in accordance with the prudent buyer concept. Implementation of the recommended savings of non-food supplies could be ascertained only if we were to wash dishes without soap, not maintain cooking equipment as they break, not change and clean duct filters as required by law, not replace dishes when broken and rationing napkins to patients on a daily basis.

....7

We have, to date, eliminated a selective menu which was a most outstanding feature of the nursing center and which our resident population was most appreciative of. This has enabled us to reduce food and labor costs. Any further savings cannot be implemented by this facility, if we are to provide adequate food portions for our patients.

CLEANLINESS AND SAFETY

We have in our appeal letter of November 17, 1976 documented the need of existing staffing based on our physical facility which has more square footage per bed than many other facilities. As previously stated, eighty-two per cent of our patient rooms are single bedded rooms and eighteen per cent are two bedded rooms, each with a private bath.

Any further reduction in staff would result in rooms not being cleaned daily, corridors not routinely buffed and bladder accidents not attended to as promptly as before. Given the percentage of incontinent patients residing in our facility, we have, to date, been proud of a meticulously clean and odor free facility. Should further staff reductions be implemented we are very much afraid of having odors permeate the facility given our acutely ill population, and have a facility that no one identifies as a true "home" reminiscing to their past, but identifying the Margaret Tietz Center for Nursing Care as an "institution".

SOCIAL SERVICE

Social Service is most essential to our mission of meeting the needs of nazi victims. The State must be cognizant of the special cultural needs and demands on social service by this patient population. We have a very fragile group of people to whom institutionalization surfaces very many depressed anxieties, fears and anger, related to the holocaust.

We must have a very sensitive, sophisticated and professionally trained social service staff. It is only with such people that we can truly meet the intense social service needs of our population.

Should recommended reductions be implemented, we very much fear that the following can and will happen:

....8

-Patients problematic inter-personal relationships will not be dealt with and can lead to inadequte utilization of more professionally costly personnel, such as psychiatry.

-Patients will not be motivated to use the rehabilitative and restorative services leading to more costly care.

-The institutionalized nazi victim, many who lost their entire families to the nazi holocaust will now have lost their surrogate social service families to the financial holocaust.

Lack of professionally trained social workers will lead to deprivation of prescribed medical, nursing and rehabilitative care because of the needed interpretive job the social worker assumes to the ethnic, cultural and emotional background of our patients.

Absence of staff will remove the individual from motivation of "living to the fullest within his disabilities".

Any reduction of social service staffing or calibre of staff will lead to dehumanizing our fragile population. This is an experience that most of our patients have already, unfortunately, gone through and which we cannot permit to occur again. It is our responsibility to see that they live their remaining lives in the most humane way possible by providing for all of their social service needs.

RECREATION

Our recreation activities and programs are all geared to have a therapeutic benefit which is so necessary to our patient population. Our staff are professionally trained to achieve maximum therapeutic benefits. Any reduction of recreational activities will severely reduce these benefits and will jeopardize the very good rating received for this discipline.

CONCLUSION

The above merely addresses itself to proposed recommendations having implications for direct patient care in each discipline. Our position with regard to the remaining recommendations effecting patient care indirectly and the over-

....9

all management of the nursing center, have been expressed previously.

We are most concerned at this point in time with recommendations effecting direct patient care and wish to reiterate them for your immediate consideration due to its devastating effects on patient care services.

Very truly yours,

DAVID GLASER
Administrator

DG:nm

EXHIBIT D

Mohawk Valley Nursing Home
INCORPORATED

295 WEST MAIN STREET, ILION, NEW YORK 13357

Telephone (Area Code 315) 895-7474

HOWARD E. COLLINS
ADMINISTRATOR

THOMAS A. MORRIS
President
ANTHONY J. DELUCA
Vice President
JAMES W. ALLSTON
Secretary
PAUL J. CONSOLAZIO
Treasurer
CHARLES E. MALLERY
Immediate Past President
Assistant Treasurer
ANGELO CARDINAL
RICHARD A. HOBART
HARRY W. STALEY

January 28, 1977

Glenn E. Haughie, M.D.,
Deputy Commissioner
Bureau of Health Care
Standards & Enforcement
State of New York Department of Health
Tower Bldg., E.S.P.
Albany, New York 12237

Inre: Special Meeting with Department of Health Representatives, Tuesday, 25th. January, 1977.

Dear Doctor Haughie:

This will serve to summarize the events and conclusions of the subject meeting which Mr. Collins and I were summoned to attend by a telephone call from Dr. Frank W. Furth on Thursday, 20th. January, 1977.

I feel compelled to comment that we were most disappointed at the absence of anyone from the Department of Health who had decision-making authority. Because of this the meeting was devoted to a re-hashing of those matters which had been discussed during a similar meeting in Albany on Tuesday, 14th. December, 1976 - as well as a review of the letter which you had written to me under date of 21st. January, 1977 with which Judge Greisa was copied.

Mr. Collins has responded to your letter under separate cover, correcting the mis-statements which it contained, with a covering copy to Judge Greisa that his record might be set in order.

We were frankly appalled that none of the Health Department representatives present were familiar, or for that matter, had even seen our letter of 14th. January, 1977 to Dr. Cicero in which considerable pains were taken to respond to the original cost-reduction suggestions made on 14th. December, 1977. As a matter of fact, copies were made of our copy of this letter to acquaint the Department's representatives with our comments and proposals.

We had come specifically prepared to address these proposals as being our assessment, documented by statistics, of the maximum extent by which staff could be reduced without a serious and irreparable slippage in patient care.

The Department representatives, obviously upon instruction, held to the hard line that the only acceptable reduction was the implementation of the 14th. December, 1976 proposal which we had conclusively decided after in-depth consideration, was capricious and unreasonable.

The other major unreconciled problem was the matter of the "mid-cycle" nature of our rating which should have prevented its application to establish a rate. The Department had conceded the "mid-cycle" nature of the rating by agreeing to change the "Needs to Improve" classification of Cleanliness and Safety, which in turn would result in a $2.40 increase to the Nursing Home per diem.

However, the more serious question which we have raised on several occasions of why "Good Federal" should have been applied to our Nursing Service was not answered nor apparently even considered. The nursing costs comprise the largest single cost factor and, while we have never been advised specifically despite requests for information, we are sure comprise the greatest amount of reimbursement reduction because of the application of the 35th. percentile.

The Department representatives were also unable to respond to the "pass-through" which should result from the "Very Good" rating which the regional surveyor reported for our Dietary Service as a result of the October 1976 survey.

The meeting was concluded in total frustration because the Department representatives were unable to make independent judgements and were restricted to reiterating the initial, unacceptable and unworkable Department position. The amount of time which was wasted in this exercise in frustration is a concern of ours and should be a concern of yours, if the Department of Health has any real inclination to resolve the reimbursement problems of the Mohawk Valley Nursing Home.

The year end figures, unaudited, indicate a total operating loss of $241,000 - with the total years expenses equating to a cost per day for Medicaid patients of $54.53. This is 9¢ more than the per diem cost reported to Judge Greisa's court as of 30th. September, 1976.

The point was made, and should be reinforced, that these costs represent money which has been spent and which - in no way - can be recouped from vendors or staff. The Nursing Home, therefore, has no room for negotiation because there is no source for funding the deficit.

In addition, the revised budget figures for 1977 reflect a per diem cost of $58.30 which likewise must be provided if the Nursing Home is to remain fiscally viable. This includes the reduction in staff of seven (7) aides which has been accomplished. We had hoped that the Department would be inclined to consider the sincerity with which this staff reduction was accomplished, as well as our concern for patient care, should further reduction be considered.

The conclusion has been reached that a staff reduction of 20 would reduce the level of patient care to the warehousing of human beings. We cannot, and will not, tolerate Nursing Home residents being forced to lay in their own urine and feces because nursing time is not available to promptly care for them. The decubiti caused by this neglect would require further nursing time leading to additional neglect. The multiple compounding of problems is obvious.

Services to the Nursing Home are provided by the Mohawk Valley General Hospital, and if the Nursing Home becomes insolvent and unable to pay unsecured creditors, it will be the Hospital which suffers from this situation. The Hospital and Nursing Home Board have no intention of imposing a Nursing Home deficit upon the residents of the owning Townships.

It therefore becomes utterly imperative that provision for adequate and justified reimbursement be made immediately. Until this is accomplished, the Nursing Home must commit all available cash resources to the payment of operating expenses before capital costs can be considered. We can only say, without any intention of being dramatic, that every day - and, indeed, every hour of delay - only serves to bring the inevitable, irreversible confrontation nearer.

If there is any good will, or reasonableness, we implore that it be demonstrated.

Very truly yours,

MOHAWK VALLEY NURSING HOME, INCORPORATED

Thomas Morris

Thomas A. Morris, Esq.,
President, Board of Managers

Howard E Collins

Howard E. Collins,
Administrator

EXHIBIT E

airman of the Board
ecutive Director
norary Presidents
J. C
Rousso
n. Chairman of the Board
rst Vice President
e Presidents
Arias
Cohen
Goldberg
Hazan
ecretary
Rousso
ecording Secretary
Cohen
easurer
Rousso
ntroller
J. Hasson
edical Director
M.D.
ssociate Director
Cohen
aplains
Arnold B. Marans
Dr. Louis C. Gerstein
oard of Directors
Arias
Altchek
Arias
Arias
Baker
J. Cohen
David
Elias
Elias
Elias
R. Elyachar
Leonard Finz
Goldberg
J. Hasson
Hazan
Levy
Nahoum
Rousso
Rousso
Sabato
dies Auxiliary
Counsel
ector of Development
Daiken

393

THE SEPHARDIC HOME 2266 Cropsey Avenue,
Brooklyn, N.Y. 11214 · CO 6-6100

January 27, 1977

Dr. Frank T. Cicero
Deputy Commissioner
New York State Department of Health
Tower Building - Empire State Plaza
Albany, New York

Dear Dr. Cicero:

On January 15th, I was invited to meet with your staff on January 19th in Albany. Although the purpose of the meeting was not completely clear to me, we attended the meeting in the hope that it was an attempt to reconcile the differences which exist between the new reimbursement rates and the cost of the level of services essential to the welfare of our residents.

On January 13th, I had submitted an appeal on the November reimbursement rate. The tone of the meeting on January 19th was laid down at the very outset by the chairman who stated that the purpose of the meeting was simply for the Department of Health to make their recommendations to us for the reduction of our staff to the degree that we could function within the million dollar reduction in the reimbursement for our Home.

It is interesting to note that I received a negative response when I asked if the reduction in staffing would bring with it any reduction in the greatly increased paper work required by the State during the past two years and which we found to consume a large segment of the time previously devoted to patient care.

I was advised that as a Licensed Administrator, I was responsible for being in compliance with all the code requirements regardless of the recommended decreases in our staffing.

In the matter of cutting back a substantial number of our Nursing Staff, I wish to call your special attention to the serious contradiction in the position taken by you as to what staffing is required for good nursing care. As recently as three weeks ago, I was advised by one of your Nursing Surveyors, who knows our Home well and who had inspected our Home on several occasions, that based on her knowledge of the needs of our patients at first hand, it would be best that we do not cut our Nursing Staff at all.

When your Sanitarian suggested that I could cut three members of the Maintenance Staff, I asked if he was aware that he was not permitting me sufficient staff to cover the Fire Department, Building Department and Safety Code requirements. I pointed out that it would be impossible for the Home to cover a 168-hour week with the remaining three men who would provide 105 hours. Your surveyor shook his head and started to say that he was not aware of the regulations. The chairman broke in and stated that I was not being cooperative; that the recommendations were that of the expertise of the surveyor.

In a spirit of being as cooperative as possible, I requested each of the Surveyors who met with us, if they could inform me as to how many people would constitute appropriate staffing for each department. I was able to receive an answer only for the Social Service and Recreation Departments. In the case of Social Service, I took the number of suggested positions and salaries, annualized the figures, divided the results by our patient days and arrived at 44¢ per patient day. On your computation sheets, the maximum allowed was 21¢ and 28¢ for our Health Related and Nursing Home patients respectively. When I asked for an explanation of the inconsistency between suggested minimum staffing and the ceiling, I was told that my observation would be noted, but there would be no increase in the ceiling; we would have to cut services in other areas to make up the difference.

It is obvious that your staff was under direct orders to show us how to reduce our operating costs by a million dollars. Required programs and patient care was not even mentioned or considered by your staff. In our experience, these recommendations completely ignored the safety and well-being of our residents.

When I stated that if I complied with your suggestion to reduce staff, I would obligate the Home to severence pay and unemployment insurance. Would we be allowed this additional expense to the Home? I was advised that my comments were interesting and they would be noted.

When I asked if the DSM1's which we had submitted for the Sephardic Home patients had been evaluated and equated to the proposed staffing, I was advised that there hadn't been sufficient time, but it really didn't matter; the cuts should be implemented in any event.

At the meeting, I pointed out that I had requested information so that I can file an intelligent appeal. That request has been ignored. I also requested copies of the source material. I was told this would be provided. As of this writing, it has not been received.

I advised your staff that by letter I had requested a copy of the groupings so that I could evaluate who I was grouped with to determine the ceilings. The computer run-off of the ceilings was provided to me; however, it seems that the Sephardic Home, one of your higher cost institutions, was not on the list. My question is, how could you develop valid and fair averages or come to the 60th percentile if not all institutions are included on your listing?

Regarding labor costs in the philosophy of the state-wide ceilings by dollars, I think it is important that it be brought to your attention that a dollar ceiling in any given area will not result in the equal amount of service purchasable for the same dollar. The million dollars spent in the New York City area in an institution having a contract with Local 1199 will buy about 50% of the service of a non-union institution in the upstate area.

As I have said in my letter of January 13th, it is unconscionable and unfair for you to penalize us when another arm of your state government negotiated and arbitrated our union contract. At no time did we ever give the union staff a raise without the arrangement and negotiations being handled by the executive branch of the state government.

It is our contention that our staff for the care of our patients was reviewed and adjusted in 1975. Prior to 1975, the Sephardic HOme had 185 employees for 163 patients. We

January 27, 1977

Dr. Frank T. Cicero

have 221 employees with 261 patients. As a result of the aforementioned, we now have a change in our ratio of 1.13 to .85 employees per bed. When I pointed this out to your staff in Albany, I was advised that we should cut even further.

Please bear in mind that we are still required to conform with all codes and regulations regarding paper work and documentation in order to receive even the reduced reimbursement.

I am herewith attaching for your review a letter from our Medical Director and a detailed memorandum from our Director of Nurses and her two assistants relative to the impact on our patients should we institute the reduction recommended by you. I am also attaching a list of recommended staffing cuts. In addition to staffing cuts, there were expense cuts recommended.

Dr. Cicero, there must be some way for the State to balance its operating deficit without condemning the residents of this Home to heartless neglect, which we know would result from the reduction in our staff to the extent recommended by your representatives.

Respectfully,

SEPHARDIC HOME FOR THE AGED

Herbert Freeman
Executive Director

HF:mw
Enc.

of the Board
Director
Presidents
of the Board
President
Secretary
Director
Director
Directors
Development

397

THE
SEPHARDIC
HOME 2266 Cropsey Avenue,
Brooklyn, N.Y. 11214 · CO 6-6100

January 25, 1977

Dr. Frank T. Cicero
Deputy Commissioner
New York State Department of Health
Tower Building - Empire State Plaza
Albany, New York

Dear Dr. Cicero:

As the Medical Director of the Sephardic Home for the Aged, I also attended the meeting in Albany on January 19th, together with the Executive Director,the Director of Nursing and our accountant.

One of the proudest segments of my professional career, extending over a period of almost fifty years, is the twenty-five years I spent as the Medical Director of the Sephardic Home. I have seen the advances made by medical science and nursing skills translated into the daily lives of countless aged and infirm patients, bringing with them a measure of comfort and happiness to their increased life span.

To be sure, to retard or to reverse the illness of an aged patient requires a sense of skill and dedication that is difficult to realize, unless you see the destructive and inhuman effects of their neglect. The time consumed in the rendering of good care is much greater for the aged patient than in other age groupings, but the results are most gratifying. I must emphasize that the results of inadequate staffing and services can only lead to the most dehumanizing effects on the helpless aged, who do not even have the strength to defend their own interests.

In an accompanying report, the Director of Nursing has detailed some of the consequences of inadequate medical and nursing care to these aged, whose health is so fragile that constant vigilance is an absolute requirement if their increased years are to have any civilized meaning.

January 25, 1977

Dr. Frank T. Cicero
Deputy Commissioner
New York State Department of Health

I add my assurance that in the aged the devastating consequences of insufficient nursing and medical care are ever-present, and would rapidly and inevitably occur if the program outlined to us in our meeting in Albany were to be carried out. It is imperative that the fiscal restrictions be visualized in terms of human suffering.

It has been properly said that the mark of a civilized people is their genuine concern for and about their aged.

Respectfully,

SEPHARDIC HOME FOR THE AGED

Joseph Dalven

Joseph Dalven, M.D.
Medical Director

JD:rha

SEPHARDIC HOME FOR THE AGED

January 25, 1977

TO: MR. HERBERT FREEMAN, EXECUTIVE DIRECTOR

FROM: MRS. JOSEPHINE MITTELMARK, R.N., DIRECTOR OF NURSING

On Wednesday, January 19th, 1977, I participated in a meeting in Albany concerning an appeal to maintain the level of care given to our patients and residents at the Sephardic Home for the Aged-a level of care that we are proud of and that reflects itself in the well-being of those aged entrusted in our care.

Through the years the State Department of Health worked hand in hand with our Nursing Administration to maintain and improve the standards of care and the quality of life for our elderly. Our combined efforts contributed to the excellent care given the patients in our Home.

If I were to implement the substantial cuts in the Nursing Staff recommended by the Hearing Board, I feel the consequences of this act would be devastating to those whose lives have been entrusted to us. If our present standards of care are diluted by the State Board's cuts in personnel, I feel that chaos will be the final result.

In my professional judgment the following would occur:

1. Many moderate to severely organic brain syndrome patients would deteriorate mentally and lose all contact with reality.

2. Patients would not be able to be taken out of bed as often, resulting in decubitus ulcers and pressure sores.

    a) Fewer staff members would result in delays in getting people up; patients would either be sitting up for longer periods (begging for bed) or being returned to bed too soon. Both instances would result in a rapid deterioration of patients mentally and physically.

    b) Naps after lunch would not be feasible.

3. Safety of the patients would be in jeopardy.

    a) Patients who cannot ambulate safely without assistance and/or supervision would be neglected.

    b) Patients who are being restored to ambulatory status with restorative nursing rehabilitation would deteriorate.

c) Many wanderers would not be supervised sufficiently.

RESULT: 1. Many falls and Fractures
Wanderers unattended (Increase in use of restraints)

4. Many patients on psychiatric medications must be observed carefully.

5. Many depressed and anxious patients would become more so due to lack of mental stimulation and supportive techniques.

6. The number of times per week the patients are bathed would be drastically reduced.

RESULT:
1. Poor hygiene
2. Decubitii
3. Irritation and infection from excreta

7. Patients would not receive restorative care as before.

RESULT:
1. Contractures
2. Decubitii
3. Loss of Mobility

8. Many patients on bladder and bowel rehabilitation programs would suffer.

RESULT:
1. Increase in incontinence
2. Poor hygiene
3. Decubitus Ulcers
4. Infection

9. Large number of blind patients who require a one-to-one relationship for remotivation and reorientation, would be frequently left alone.

10. Large number of patients who require spoon feeding which takes 20 to 30 minutes per patient, would be rushed to eat, or would not eat as much.

RESULT:
1. G.I. distress
2. Weight Loss
3. Dehydration

January 25, 1977

TO: MR. HERBERT FREEMAN, EXECUTIVE DIRECTOR

11. Special X-Rays must be done. Preparations take time.

12. Many patients require supplemental feedings. Time spent would be decreased.

RESULT: 1. Dehydration

13. Many patients wear contact lenses which require skilled staff to insert and remove daily. This sophisticated and delicate prosthetic device cannot be handled by the unskilled, or the patients themselves.

14. We have patients on chemotherapy who must be carefully observed.

15. Patients will not be transported to therapist.

RESULT:
1. Mobility will be lost
2. Activities of daily living would be discouraged
3. Recreation: Rather than doing and participating, people will sit and stare.

Care will become automatic and there will be little time for individual attention. Patient care would become an "assembly line."

There would be an increase in accidents and falls. Safety would be at stake.

The quality of care would decrease.

The number of decubitii, upper respiratory infections, pneumonia, contractures, anxieties and depressions, and deaths, would surely increase.

The elderly patient would be robbed of his dignity, pride and of his years.

The losses he already suffers because of his age and infirmities cannot but bring more sadness and a quicker death.

January 25, 1977

TO: MR. HERBERT FREEMAN, EXECUTIVE DIRECTOR

One measure of a society is the quality of care provided for the aged. It is difficult to think that the goals achieved during these past years to maintain the human dignity and self-esteem of these individuals are now being taken away.

Josephine Mittelmark
Josephine Mittelmark DNS

Mary Ann Morelli
Mary Ann Morelli ADNS

Jeanette Charvet
Jeanette Charvet ADNS

RECOMMENDED STAFFING CUTS

HOUSEKEEPING

Housekeeping Supervisor	1
Maids - Porters	5

MAINTENANCE

Maintenance Men	3

DIETARY

Dietician	1
Supervisor	1
Diet Aides	4
Cooks	2-1/2

Staff Reduction to 26

NURSING

R. N.	1
L. P. N.	9
Nurses Aides	16
Orderlies	7
Medical Clerks	5

ADMINISTRATION : Salary cuts to equal - $118,000.00

SOCIAL WORK

We should have:

MSW	1
Social Work Assistant	1-1/2

LEISURE TIME

Should be:

1/2 hr. per patient = 130.5 hours

We have . . . . 170 "

PHYSICIANS: Cuts - $58,000.00

EXHIBIT F

Mary Manning Walsh Home
1339 York Avenue, New York, New York 10021
(212) 625-2800
Carmelite Sisters
for the aged and infirm

January 21, 1977

Frank T. Cicero, M.D.
Department of Health
State of New York
Tower Building
Empire State Plaza
Albany, New York 12237

Re: New York Association of Homes
for the Aging, Inc. et al v.
Philip L. Toia et al.
76 CIV 5113

Dear Doctor Cicero:

At a meeting held in Albany on January 19, 1977 at the office of the New York State, Department of Health, we stated that we would send you our version of that conference. It might be added that we were given only two days notice of the conference and no indication of what the agenda would consist of. In that limited time, we gathered as much documentation as we thought would be necessary to state our position and to inform your staff of our present level of operation. Attached please find a list of the documents we brought to the conference.

Our overall impression of that conference was that your staff, although acting in good faith and with sincerity, had relied upon out-of-date information concerning Mary Manning Walsh Home in their recommendations to us. As an example, under the discipline - Nursing Service - your staff recommended a floor by floor dismissal of certain Registered Nurses and the hiring of additional Licensed Practical Nurses. This recommendation was based upon a May 1976 survey. Your staff had the knowledge that our Home 's certified capacity had been changed for Skilled Nursing from

271 beds to 301 beds and Health Related Facility beds from 76 to 61. This new certification, of course, necessitated moving some Residents from one floor to another. Therefore, your staff's recommendation for discharging certain Registered Nurses and replacing them with Licensed Practical Nurses had no validity. In other cases, we had already terminated more personnel than your staff was recommending. In certain areas of your staff's recommendations, we are beginning to review the situation namely in the area of dietary program and administrative cost.

We left with your staff a report dated January 7, 1977 entitled "Intensity of Care" and summary of social service activities for 1976 and a statistical breakdown of that report of the month of December 1976.

Another item of deep concern to us, as we mentioned at the conference, is your letter to Judge Thomas Griesa, District Judge of the Southern District of New York, dated January 6, 1977 in which you informed Judge Griesa that Mary Manning Walsh Home's daily rates had been increased as follows: Skilled Nursing Facility from $53.48 to $65.55 and the Health Related Facility reduced from $37.73 to $36.36. As of this date we still have not received from you an official notice of our rate increase and rate decrease as you informed Judge Griesa. Our Home is still receiving funds based upon the rates promulgated in November 1976 which are Skilled Nursing Facility $53.48; Health Related Facility $37.73. You know, of course, that Mary Manning Walsh Home's financial condition is getting more precarious each day that passes. We have the feeling that Judge Griesa believes we are actually receiving the funds based upon your letter as stated above. We do not know exactly how long our Home can operate if we do not receive some relief in the immediate future. At the conference, we believed that it was the intention of both parties to arrive at an equitable and fair solution to the financial problems of the Home. We informed your staff that it was our sincere belief that our daily rates as of November 30, 1976 should be for Skilled Nursing Facility beds $67.88 and for Health Related Facility beds $35.06. With these rates we believe we can operate Mary Manning Walsh Home as efficiently as ever with a view to cutting costs wherever we can, while keeping in compliance with the Codes, Rules and Regulations of Title 10.

We arrived at our proposed daily rates of $67.88 and $36.06 as follows:

	SNF	HRF
Rates granted 11/30/76	$65.55	$36.36
Granting our Appeal Item #1	-	1.12
Granting our Appeal Item #2	.08	.08
Rate adjusted based on Intensity of Care and Patient Mix	2.25	(-2.50)
Proposed new Rate as of 11/30/76	$67.88	$35.06

These rates of $67.88 and $35.06 would, of course, have an automatic increase of 4% as of January 1, 1977 as was negotiated between the Department of Health and Judge Griesa which would result in a new daily rate of $70.60 for Skilled Nursing Facility and $36.46 for Health Related Facility.

We wish to point out that if the initial reduced rates promulgated in November 1976 are applied retroactively to January 1, 1976 it would result in the Mary Manning Walsh Home having an immediate liability to the Department of Health of approximately $1,050,000. While the granting of the rates we are seeking as stated above, together with continued efforts in cost containment will hopefully assure our ability to continue our program of intensive quality professional care, the retroactive liability to January 1976 would put the Home in an unmanageable deficit position. We, therefore, urge that either the Department of Health or the Courts order the elimination of the retroactive liability.

Attached is a record of our understanding of your staff's recommendations to us at the conference in Albany and our reply thereto.

We are aware that a report of the several conferences held by your staff on January 19, 1977 is to be submitted to Judge Griesa by January 26, 1977. In the interest of time, we are sending a copy of this letter and its attachments directly to Judge Griesa.

We realize that these are difficult times for the Department and for the Home. In our mutual concern for the welfare of the aged people you know our co-operation is dedicated and sincere. We are grateful to you for your concern and help.

Sincerely,

Mother M. Aloysius

Mother M. Aloysius, O.Carm.
Administrator

cc - Honorable Thomas Griesa
District Judge, Southern District of New York

MARY MANNING WALSH NURSING HOME COMPANY, INC.

408

Inventory of Documents - Management Assessment Meeting

Albany, New York January 19, 1977

N. Y. State Department of Health 10:00 A.M.

1.	1976 Budget submitted to N.Y.S. Department of Health	W.L.L. carries
2.	1977 Budget submitted to N.Y.S. Department of Health	"
3.	1975 HE-2V	"
4.	Payroll Totals Recap 1976 w/e 12/26 & YTD	"
5.	Payroll Register w/e 12/26 & YTD	"
6.	Appeal Letter dated 1/12/77	"
7.	Part 86.2 of the Public Health Law	J.V.H.
8.	Ammended Part 86.2 of the Public Health Law	J.V.H.
9.	Rate Computation Sheets (HE-12)	W.L.L. carries
10.	1974 HE-2V	"
11.	Rating Certificate SNF 1/11/77 & HRF 11/17/76 (with my summary)	W.L.L. carries
12.	1975 Audited Statement by C.P.A.	"
13.	Letter dated 1/5/77 from Dr. Cicero to Mother requesting certain financial data	"
14.	Hospital Memo announcing Reimbursement Rates for 1976 - Residential Health Care Facilities	"
15.	Letter dated 1/11/77 from Dr. Michelin to Mother revising our operating certificates	"
16.	Report on Intensity of Care Program dated 1/7/77	J.V.H.
17.	Letter dated 1/6/77 from Dr. Cicero to Judge Griesa setting forth new rate for Mary Manning Walsh	W.L.L. carries
18.	File " NY State Bureau of Provider Audit"	"
19.	The Eleventh Annual Executive Compensation Survey - 1975	T.B.

MARY MANNING WALSH NURSING HOME COMPANY, INC.

REPORT ON THE
MANAGEMENT ASSESSMENT MEETING
IN
ALBANY, NEW YORK
ON
JANUARY 19, 1977
CONTAINING THE
DEPARTMENT OF HEALTH'S RECOMMENDATIONS
AND
OUR ANSWERS THERETO.

MARY MANNING WALSH NURSING HOME COMPANY, INC.

New York State Department of Health Cost Reductions Recommendations	Mary Manning Walsh Nursing Home Co., Inc. Responsive Comments
A) Social Services Department:	A) Social Services Department:
1) Recommends elimination of ½ of a secretial/clerical position cost, which when fringe benefits are added, would yield an annual savings of $6,300.	1) We agreed to examine with our Social Service Director, the feasibility of such a reduction. However, it was pointed out that the surveyor's recommendations were based on a total capacity of 347 residents whereas in fact the present total capacity is 362 residents. The oversight of the constantly increasing number of forms mandated by regulatory agencies requiring an increase of clerical work hours raises doubts as to the validity of the surveyor's recommendation.
3) Dietary Department:	B) Dietary Department:
The surveyor recommended that the present system of food service, characterized as being a "decentralized" system, be completely changed to a "centralized system. Most of her recommendations as to specific cost reduction possibilities were recognized by her as being wholly contingent upon this change. The specific cost reduction recommendations based on a "centralized" system are: 1) Eliminate 5 full time Dietary Aides. 2) Eliminate 5 part time Dietary Aides. 3) Eliminate 1 Chef. 4) Eliminate 1 Cook. 5) Eliminate 1 Dietitian. 6) Eliminate 1 position from Dietary Store Room. In addition, other recommendations not predicated on changing to a "centralized" system are as follows: 7) Eliminate free employee meals. 8) Re-examine selling prices in Coffee Shop with a view toward increasing gross revenue.	The Home some months ago initiated a feasibility study to determine the capital costs for equipment, the cost of building alterations, and the potential cost savings involved in a change to a "centralized" system. The building was originally planned, and approved by the Department of Health to physically accommodate a "decentralized" food service system. Certain features such as floor pantries and floor dining rooms would be eliminated under a "centralized" system, and therefore we must also take into consideration the additional costs to provide staff for feeding incapacitated residents in their own rooms who are now hand fed by the present staff in these floor dining-rooms. Items #1 thru #6 - These will be investigated concurrently with the ongoing feasibility study mentioned above upon which most of them depend Item # 7 - This is not feasible due to the fact that our union contract contains a Past Practices Article and employees have been given free meal ever since the Home commenced operations over years ago. The Department of Health has been aware of this union contract provision for the pas 7 years and has reimbursed it for this cost. Item # 8 - This will be re-examined.

MARY MANNING WALSH NURSING HOME COMPANY, INC.

9) Investigate to verify that overtime costs are at a less costly level than any other alternative and/or that emergency situations justify overtime pay.

10) The quality of food served is excellent and therefore there is no cost reduction amount related to wastage.

11) The raw food cost is in line with Department of Health guidelines and therefore there is no cost reduction amount recommended.

12) The summary of savings expected, as presented by the representative of the Bureau of Reimbursement Rate Setting, is as follows:

a - Salaries & Fringes	$205,000
b - Food	5,000
c - Employee Meals	133,000
Total	$343,000

Item #9 - This has been investigated and the Home will continue to investigate to verify that all of the overtime paid is unavoidable and the least costly alternative available when legitimate absenteeism in the patient service areas occurs. An 11 day strike in July 1976 necessitated extensive overtime.

Item #10 - The Home is gratified to receive a complimentary report about its efforts to eliminate waste by always serving high quality meals.

Item #11 - The Home is similarly gratified to receive a complimentary report about its raw food cost as presented by the Food and Nutrition Surveyor of the Department of Health.

However, the Home is not pleased to observe the apparent contradiction by another Bureau of the Department of Health. In Item #12 the summary of recommended cost reductions as presented by the Bureau of Reimbursement Rate Setting includes a $5,000 cost reduction in Food (see Item #12 B).

Item # 12B - No specific comments about the summary were proffered.

MARY MANNING WALSH NURSING HOME COMPANY, INC.

Nursing Service Department

The surveyor made the following recommendations for eliminating and changing staff positions by floor.

1) - 2d floor

Eliminate Unit Manager
Eliminate 1 day shift aide
Reduce Nurse coverage from RN to LPN on evening shift
Eliminate 1 night shift aide
Change coverage to 1 LPN from ½ RN on night shift

2) - 3d Floor

Increase coverage from ½ RN to 1 RN on day shift
Eliminate 1 LPN on day shift
Eliminate 1 aide on day shift
Change 1 RN to 1 LPN on evening shift
Eliminate 1 aide on evening shift
Change coverage to 1 fulltime LPN from ½ RN on night shift

3) - 4th floor

Eliminate 1 RN on day shift
Eliminate 1 aide on day shift
Reduce nurse coverage from 1 RN to 1 LPN on evening shift
Change coverage from ½ RN to 1 LPN on night shift

4) - 5th floor

Eliminate 1 LPN on day shift
Eliminate 1 aide on day shift
Change coverage to 1 LPN from ½ RN on night shift

Nos. 1 through 9

The surveyor who recommended the reductions specified in Items 1 through 9 admitted that such recommendations were made without consideration of the following:

a) taking into consideration the present patient mix (as of November 30, 1976) resulting from recertification increasing the number of SNF beds.

b) determining whether or not the facility would in fact meet the mandated level of care contained in the Department of Health Code.

c) utilizing the present level of staffing in making her recommendation. Instead she used a staffing pattern which she obtained at the time of her survey in May 1976. This pattern has been substantially reduced since that time.

d) referring in any fashion to the intensity of care required by the Residents as outlined in the document entitled "Report on Intensity of Care Program - January 7, 1977", submitted to the Moderator and previously submitted to the Bureau of Research and Evaluation.

5) - 6th floor

Eliminate 1 RN on day shift
Eliminate 2 aides on day shift
Eliminate 1 RN on evening shift
Eliminate 1 Aide on Evening shift
Change coverage to 1 LPN from 1/3 RN on night shift

6) - 8th floor

Change coverage to 1 RN from ½ RN on day shift
Reduce nurse coverage from RN to LPN on evening shift
Eliminate one aide on evening shift
Eliminate one aide on night shift
Change coverage to 1 LPN from 1/3 LPN on night shift

7) - 9th floor

Transfer ½ RN from 8th floor day shift
Reduce nurse coverage from RN TO LPN on evening shift
Change coverage from 1/3 LPN to 1 LPN on night shift
Eliminate 1 aide on night shift

8) - 10th floor

Eliminate ½ RN on day shift
Change coverage to 1 LPN from 1/3 RN on night shift

9) - HRF

Eliminate 1 aide

10) - The complex recommendation of the nursing surveyor would make it appear that the recommendation is to eliminate 21 full time and 1 part time persons in Nursing service and to substitute nine Practical Nurses for nine full time and one part time registered nurses.

The anticipated cost savings estimated by her would be $239,000.00

#10 - The anticipated savings calculated on the summary contained herein has completely neglected to consider the following:

a) The financial exposure of the Home to the increased cost of Unemployment Insurance which could grant each of the 21½ people eliminated payments of $95.00 per week.

b) The relatively small differential in salary betwen LPN and RN which does not equal the $95.00 unemployment insurance payment.

c) The increased necessity for additional coverage for absenteeism, etc. which is brought about by the reductions recommended. This additional expense would take the form of overtime being worked at premium pay or additional staff.

The Home is presently engaged in an in-depth study of the actual condition of the patients to determine the intensity of care needed. The results of this study should determine what changes if any that can be made in the present staff and still maintain the needed level of care.

Reference is made to a report and DMS I forms submitted to the Department of Research and Evaluation of the Health Department describing the high level of intensity of care required by and delivered to a large percentage of patients maintained in the Home. The recommendation for the reduction of quantity and quality of service made by the surveyor is impossible to implement with such a patient load. The acceptance of such a recommendation would require intervention of the Board of Directors regarding a change in philosophy of care and policy of intake.

MARY MANNING WALSH NURSING HOME COMPANY, INC.

Administration

1) The following positions were recommended for elimination:

1 - Assistant Administrator
1 - Director of Communication
1 - Director of Purchasing
1 - Assistant Director of Finance
1 - Paymaster
3 - Secretaries
2 - Clerks
1 - Bookkeeper
1 - Personnel employee
2 - Storeroom employees
1 - Director of Training
15

2) Physicians' salaries should be examined to eliminate any overage.

3) Peripatology (aid to the blind) costs are not reimbursed and should be eliminated - $7,500.

4) An amount of $1,500 should be reduced from the Beauty Shop and Barber expense.

5) The deficit generated in the Coffee Shop of $20,000 should be eliminated.

6) The level of Administrative Salaries should be examined.

7) The budget for publications should be examined to see if there is excess spending.

The entire group of recommendations were predictated on the assumption that the Administrative costs of the Home were $300,000 in excess of ceiling imposed by the group average. However, the average used was for the "100 to 299 bed" grouping while the Home is now in the "over 300 bed" grouping. This reflects an entirely new and higher ceiling which was not taken into consideration.

#1) It is impossible to react realistically to a "laundry list" of job titles recommended for elimination without considering some logical method of operation based on duties rather than titles. A study of the Administrative area will be made to determine if a method of organization can be devised which will result both a saving in cost and an efficient operation.

#2) Changes have already been made due to our cost containment program which undoubtedly will reduce the physician's salaries below the required level.

#3) There are 82 blind patients in the Home requiring different levels of service from a peripatologist. Adequate care cannot be provided to these blind people without this specialized service.

#4) The surveyor's recommendation is based on an outdated report subsequent to which the deficit has been eliminated by increased prices. Administration believes that the entire cost of these basic hygenic services should be added to the reimbursement rate and not have to be paid for from the $28.50 personal allowance.

#5) As stated in the "Dietary Department" section methods of increasing the revenue will be investigated.

#6) All salaries in the Home are continually examined in light of the most current salary surveys available which cover the industry and geographical area in which we operate. We find that all salaries are well within the ranges listed for similar positions in similar facilities in the area.

#7) The content and costs of the budget for publications will be examined to determine the exact costs involved and any economies available will be effectuated.

MARY MANNING WALSH NURSING HOME COMPANY, INC.

1) Housekeeping It was recommended that the housekeeping department be reduced to 36 people including supervisors.	1) The present level of the Housekeeping Staff is below that recommended.
2) Maintenance It was recommended that the maintenance department be reduced from 11 employees to 10 employees including supervisors.	2) Drastic reductions in the maintenance staff have been effected over the last 3 years. Further reductions could jeopardize the upkeep of the plant and the protection of the capital investment.
3) Security It was recommended that security be staffed to provide 2 men on each of three shifts for 7 days per week.	3) This is the exact staffing pattern adhered to at present.
4) Laundry It was recommended that 1 laundry aide be eliminated.	4) The present level of staffing in the laundry is below that which was recommended since the figures used by the surveyor are not current

****

In order to put the efforts of the Administration of the Mary Manning Walsh Home in the area of cost reduction in the proper perspective, it is necessary to examine the results of 1974.

The year of 1974 marked the commencement of intensive efforts on the part of the Home to make drastic inroads into its costs. While the program had its inception in 1973, meaningful results did not appear until 1974 and 1975.

An examination of the State Department of Health's HE 2V form for 1974 will show on Page 24 that in the Skilled Nursing Facility the Home employed 347.9 full time equivalent personnel and the Health Related Facility the Home employed 66.6 full time equivalent. This did not include the Sisters due to an oversight in the report. An examination of Page 34 of the HE 2V form for the year of 1975 shows that the Home had reduced the full time equivalent employment in the Skilled Nursing Facility to 322.7 (including the Sisters) and in the Health Related Facility to 48.0 (including the Sisters). Assuming a conservative figure of 18 Sisters, this represents a total reduction in force for the entire Facility during this period of 61.8 full time equivalent personnel.

The year of 1976 will show a further reduction of approximately 30 people resulting in a payroll saving of nearly $250,000.00. Consequently, in the recommending of reductions one should view the efforts and results shown above. These reductions in cost should clearly reflect that the Administration of the Mary Manning Walsh Home is acutely aware of the financial constraints placed on all of us, and is effectively dealing with the situation while at the same time providing excellent care to the elderly.

The Concord Nursing Home, Inc.
300 Madison Street
Brooklyn, New York 11216

THE REVEREND GARDNER TAYLOR, D.D.
Founder

Founded-January, 1966

Telephone: 783-3030

January 21, 1977

Mrs. Estelle Wall,
Associate Research Analyst
New York State Department of Health
Tower Building - Empire State Plaza
Albany, New York 12237

Dear Mrs. Wall:

This letter is to acknowledge that our facility is not in agreement with actions taken by the New York State Department of Health on January 18, 1977 as the Department has failed to document or specify as per standards or regulations specific reasons for reductions. Also, I have requested that Mesdames Harker, White and Mr. Ng further clarify rationale for budget cutbacks. Also, I can not understand why the above consultants requested staff increments and mandated services eight months ago and presently request reductions in these areas.

Therefore, it is necessary that more definite answers be received from all parties.

Enclosed is summation of report which specifies necessary consideration for all services.

Thanks for your cooperation.

Sincerely yours,

Steven Silverstein

Steven Silverstein,
Administrator

SS:vk
enc.

C: Reverend G.C. Taylor
C. D'Abreu
S.D. Wright
P. Machnikoff

THE CONCORD NURSING HOME
300 Madison Street, Brooklyn, New York 11216

MEMORANDUM

TO: Mr. D'Abreu
Date: January 20, 1977
FROM: Steven Silverstein
Subject: Albany Meeting

This report is based upon meeting held January 19, 1977, 10:00 A.M. at Empire State Plaza, Albany, N.Y. regarding The Concord Nursing Home and New York State Department of Health concerning Judge Griesa's decision re: New York Association Homes For Aging injunction against NYSDH's promulgated rates for 1976.

Mr. Foley, Atty. for NYSDH presided as Chairman with Hilda White, Nursing Consultant, Renee Harker, Dietary Consultant, Ms. Hughes, Social Services-Activities Consultant, Mr. Ng, Environmental Health Consultant, Dr. Michelin, Health Program Administrator, N.Y.C. Regional Office, Alan Marshall, Assoc. Analyst, Department of Health Economics, and Steven Silverstein, Administrator, The Concord Nursing, Inc.

HILDA WHITE:

The department has reviewed the residents and costs for 1976 and state following:

Thw Home should reduce RN's from 8 Full-Time to 3.5 Full Time.
Reduction of 1 Nurses Aide and 2 LPN's.should be complied too.
Nursing supplies should remain at $40,600 per annum.

MR. SILVERSTEIN:

I disagree with reduction of RN's to 3.5 due to fact you did not include need for relief for vacation, sick, holiday time. Also, need of apparent level of care of 2.5 to 3.0 hrs. in SNF, and 1.5 to 2.0 in hrs. must be considered. However, it is possible to reduce RN salaries as personnel resign or are terminated. There is need for (1) Full-time ward clerk so that medical records are in compliance to NYSDH mandates.

In essence, we shall be unable to operate in accordance to Code mandates with your proposed reduction.

MR. FOLEY:

The department shall review your request and shall need unaudited or certified year-end report and other data requested by Dr. Cicero to be forwarded 3 weeks from 1/17/77.

MR. SILVERSTEIN:

I have all information except year-end report due to fact auditors are presently completing same. I shall forward within prescribed time.

SOCIAL SERVICES: (MRS. HUGHES)

I recommend that the Director of Social Services salary be reduced to $16,000 and that need for 2 MSW's for 123-bed facility is not necessary. The department shall allow 2 MSW's with reduction of Director's salary. Also, I recommend Admitting Clerk be deleted as your Home is at near capacity and admitting could be function of one MSW.

MR. SILVERSTEIN:

The salary reduction of Director would have to be documented. Also, criteria for same would have to be clarified. As far as deletion of Admitting Clerk, I find a need for services to remain as Admitting Clerk is responsible for secretary matters of Therapeutics Committee and maintenance of Medical Records and Admission Committee Minutes. However, review could be made if individual's time be reduced, if possible.

ACTIVITIES: (MRS. HUGHES)

Based upon requirements of the department, 30 minutes per resident per week is mandate. Therefore, find need to reduce to 1 Director, 1 Aide.

MR. SILVERSTEIN:

We shall need documentation of same and shall evaluate possibility of exploring utilization of volunteer services.

HOUSEKEEPING: (MR. NG)

I recommend that your staffing be modified whereby (1) Working Supervisor and 2 Aides be deleted. Laundry costs are .31¢/lb. and group average is .15¢/lb. I recommend cut back in this area. Supplies are $25,000 and should be cut back to group average of $14,000 per annum.

MR. SILVERSTEIN:

Your request is not reasonable and Home cannot work with reduction of staff. By the way, you recommended to Mrs. Adams and myself at NYC office that staffing pattern is acceptable. I cannot accept your reasoning. As far as laundry and supply expenses, the Home has been prudent and utilized GPS of F P.W.A. for all procurement. Also, we have priced other vendors to continuously review costs. I feel that costs for laundry are somewhat high due to fact we utilize diaper service in lieu of chucks because diapers avert decubitu ulcers. Housekeeping supplies for 1976-77 shall be in range of $25,000 to $30,000 and feel that this is necessary so that environment be maintained to NYSDH requirements as per your Code.

MR. FOLEY:

We shall review your request with other information.

SECURITY: (MR. NG)

I recommend that you cut 5 Security Guards and look into outside contractor.

MR. SILVERSTEIN:

This is ridiculous due to fact the department allowed additional guards for protection of building. The request was allowed due to fact Home is located in inner city area. The use of outside contractor has been explored and costs saved would be lost to prospective increase in pilferage.

MR. FOLEY:

This shall be reviewed by department, but Home should consider use of outside services.

ADMINISTRATION: (DR. MICHELIN)

Administration is in line, however, the position of Assistant Administrator is not needed for Home of 123 beds. The DNS or other responsible individual be delegated by Administrator to act in his absence.

MR. SILVERSTEIN:

I need documentation of same.

NUTRITION: (MRS. HARKER)

I recommend no reduction in staff. The cost of food should be reduced .24 per patient day or $10,156.32 per annum. Supplies should be reduced by $37,663 per annum. Also, all personnel should pay $1.50 per meal. Based upon statistics, I find that $54,6000 may be obtained from staff and utilized to offset food costs.

MR. SILVERSTEIN:

Harry Truman said, "Show me." I shall request of you to visit our facility and identify where these costs may be reduced. The Home purchases all merchandise via GPS, FPWA and reviews all costs weekly with other vendors. In essence, Ms. Onami shall call for your assistance.

MR. SILVERSTEIN to MR. FOLEY:

I would like to make it known to the department that all my suggestions be reviewed. All data shall be forwarded to Estelle Wall and Dr. Cicero for review. If staff must be attritioned due to NYS mandate, then a directive from department must state such due to fact Home is in arbitration with Local No. 144. Therefore, the Home must have your directive so that unfair labor practice charges are not brought forth by Local.

MR. FOLEY:

We shall take everything into consideration and notify after careful review with all present NYSDH consultants.

Meeting adjourned: 12 Noon.

c: Reverend Taylor
Messrs. C'Abreu, Machnikoff,
Wright, Nurick

EXHIBIT G

423

A

The Concord Nursing Home, Inc.
300 Madison Street
Brooklyn, New York 11216

THE REVEREND GARDNER TAYLOR, D.D.
Founder

Founded-January, 1966

Telephone: 783-3030

January 21, 1977

Mrs. Estelle Wall,
Associate Research Analyst
New York State Department of Health
Tower Building - Empire State Plaza
Albany, New York 12237

Dear Mrs. Wall:

This letter is to acknowledge that our facility is not in agreement with actions taken by the New York State Department of Health on January 18, 1977 as the Department has failed to document or specify as per standards or regulations specific reasons for reductions. Also, I have requested that Mesdames Harker, White and Mr. Ng further clarify rationale for budget cutbacks. Also, I can not understand why the above consultants requested staff increments and mandated services eight months ago and presently request reductions in these areas.

Therefore, it is necessary that more definite answers be received from all parties.

Enclosed is summation of report which specifies necessary consideration for all services.

Thanks for your cooperation.

Sincerely yours,

Steven Silverstein,
Administrator

SS:vk
enc.

C: Reverend G.C. Taylor
C. D'Abreu
S.D. Wright
P. Machnikoff

424

THE CONCORD NURSING HOME
300 Madison Street, Brooklyn, New York 11216

MEMORANDUM

TO: Mr. D'Abreu

Date: January 20, 1977

FROM: Steven Silverstein

Subject: Albany Meeting

This report is based upon meeting held January 19, 1977, 10:00 A.M. at Empire State Plaza, Albany, N.Y. regarding The Concord Nursing Home and New York State Department of Health concerning Judge Griesa's decision re: New York Association Homes For Aging injunction against NYSDH's promulgated rates for 1976.

Mr. Foley, Atty. for NYSDH presided as Chairman with Hilda White, Nursing Consultant, Renee Harker, Dietary Consultant, Ms. Hughes, Social Services-Activities Consultant, Mr. Ng, Environmental Health Consultant, Dr. Michelin, Health Program Administrator, N.Y.C. Regional Office, Alan Marshall, Assoc. Analyst, Department of Health Economics, and Steven Silverstein, Administrator, The Concord Nursing, Inc.

HILDA WHITE:

The department has reviewed the residents and costs for 1976 and state following:

> Thw Home should reduce RN's from 8 Full-Time to 3.5 Full Time. Reduction of 1 Nurses Aide and 2 LPN's.should be complied too. Nursing supplies should remain at $40,600 per annum.

MR. SILVERSTEIN:

> I disagree with reduction of RN's to 3.5 due to fact you did not include need for relief for vacation, sick, holiday time. Also, need of apparent level of care of 2.5 to 3.0 hrs. in SNF, and 1.5 to 2.0 in hrs. must be considered. However, it is possible to reduce RN salaries as personnel resign or are terminated. There is need for (1) Full-time ward clerk so that medical records are in compliance to NYSDH mandates.

In essence, we shall be unable to operate in accordance to Code mandates with your proposed reduction.

MR. FOLEY:

> The department shall review your request and shall need unaudited or certified year-end report and other data requested by Dr. Cicero to be forwarded 3 weeks from 1/17/77.

MR. SILVERSTEIN:

> I have all information except year-end report due to fact auditors are presently completing same. I shall forward within prescribed time.

425

SOCIAL SERVICES: (MRS. HUGHES)

I recommend that the Director of Social Services salary be reduced to $16,000 and that need for 2 MSW's for 123-bed facility is not necessary. The department shall allow 2 MSW's with reduction of Director's salary. Also, I recommend Admitting Clerk be deleted as your Home is at near capacity and admitting could be function of one MSW.

MR. SILVERSTEIN:

The salary reduction of Director would have to be documented. Also, criteria for same would have to be clarified. As far as deletion of Admitting Clerk, I find a need for services to remain as Admitting Clerk is responsible for secretary matters of Therapeutics Committee and maintenance of Medical Records and Admission Committee Minutes. However, review could be made if individual's time be reduced, if possible.

ACTIVITIES: (MRS. HUGHES)

Based upon requirements of the department, 30 minutes per resident per week is mandate. Therefore, find need to reduce to 1 Director, 1 Aide.

MR. SILVERSTEIN:

We shall need documentation of same and shall evaluate possibility of exploring utilization of volunteer services.

HOUSEKEEPING: (MR. NG)

I recommend that your staffing be modified whereby (1) Working Supervisor and 2 Aides be deleted. Laundry costs are .31¢/lb. and group average is .15¢/lb. I recommend cut back in this area. Supplies are $25,000 and should be cut back to group average of $14,000 per annum.

MR. SILVERSTEIN:

Your request is not reasonable and Home cannot work with reduction of staff. By the way, you recommended to Mrs. Adams and myself at NYC office that staffing pattern is acceptable. I cannot accept your reasoning. As far as laundry and supply expenses, the Home has been prudent and utilized GPS of F.P.W.A. for all procurement. Also, we have priced other vendors to continuously review costs. I feel that costs for laundry are somewhat high due to fact we utilize diaper service in lieu of chucks because diapers avert decubitu ulcers. Housekeeping supplies for 1976-77 shall be in range of $25,000 to $30,000 and feel that this is necessary so that environment be maintained to NYSDH requirements as per your Code.

MR. FOLEY:

We shall review your request with other information.

SECURITY: (MR. NG)

I recommend that you cut 5 Security Guards and look into outside contractor.

MR. SILVERSTEIN:

This is ridiculous due to fact the department allowed additional guards for protection of building. The request was allowed due to fact Home is located in inner city area. The use of outside contractor has been explored and costs saved would be lost to prospective increase in pilferage.

MR. FOLEY:

This shall be reviewed by department, but Home should consider use of outside services.

ADMINISTRATION: (DR. MICHELIN)

Administration is in line, however; the position of Assistant Administrator is not needed for Home of 123 beds. The DNS or other responsible individual be delegated by Administrator to act in his absence.

MR. SILVERSTEIN:

I need documentation of same.

NUTRITION: (MRS. HARKER)

I recommend no reduction in staff. The cost of food should be reduced .24 per patient day or $10,156.32 per annum. Supplies should be reduced by $37,663 per annum. Also, all personnel should pay $1.50 per meal. Based upon statistics, I find that $54,6000 may be obtained from staff and utilized to offset food costs.

MR. SILVERSTEIN:

Harry Truman said, "Show me." I shall request of you to visit our facility and identify where these costs may be reduced. The Home purchases all merchandise via GPS, FPWA and reviews all costs weekly with other vendors. In essence, Ms. Onami shall call for your assistance.

MR. SILVERSTEIN to MR. FOLEY:

I would like to make it known to the department that all my suggestions be reviewed. All data shall be forwarded to Estelle Wall and Dr. Cicero for review. If staff must be attritioned due to NYS mandate then a directive from department must state such due to fact Home is in arbitration with Local No. 144. Therefore, the Home must have your directive so that unfair labor practice charges are not brought forth by Local.

MR. FOLEY:

We shall take everything into consideration and notify after careful review with all present NYSDH consultants.

Meeting adjourned: 12 Noon.

c: Reverend Taylor
Messrs. C'Abreu, Machnikoff,
Wright, Nurick

EXHIBIT H

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

AFFIDAVIT

-vs-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

STATE OF NEW YORK)
) SS.:
COUNTY OF ONONDAGA)

EDWARD LEONE, being duly sworn, deposes and says:

1. I am the Hospital Administrator for Plaza Nursing Home Company, Inc. (hereinafter Plaza) which is a voluntary, not-for-profit corporation and which was duly incorporated and established pursuant to Article 28-A of the New York State Public Health Law on June 6, 1968. I make this affidavit in support of the position taken by the plaintiffs in their application for a permanent injunction.

Plaza accepts all people without screening out those who require expensive, special or intensive care as is customarily done in a profit making nursing home. Fifty-four percent of the patients in Plaza are on therapeutically directed special diets such as low salt, low sugar, etc. This greatly increases the cost of services to them.

Further, Plaza provides a full range of rehabilitative care and services on a staff basis. Plaza provides physical therapy, speach therapy, occupational therapy, audiology, etc. and all is provided for the needy patients on a daily basis. The patients here receive this care five days a week if necessary. In other places they would receive special care only on the one day in the week that a visiting specialist comes to render the services. This increases the cost of services over that provided in a simple health related facility or proprietary home.

2. In the most recent rating of Plaza, it received a "Good State" rating in nursing; food-nutrition; leisure time activities; cleanliness and safety; and social work. The five ratings available are "Very Good" (a rating which is very seldom given); "Good State" (which means the facility is good according to New York State standards); "Good Federal" (which means the facility meets the less rigorous standards imposed by the federal government); "Needs Improvement" (self-explanatory); and "Unsatisfactory" (this rating may result in a fine of $1,000.00 per day per violation).

3. Despite the exemplary standards maintained by Plaza and verified by the Department of Health of New York State, Plaza is advised that it will be reimbursed only 60% of some arbitrarily determined standard amount. This results in Plaza

being reimbursed at the rate of $43.42 per patient day under rates effective January 1, 1976. Plaza was actually paid at the rate of $50.50 during calendar 1976. Now, Plaza is suppose to repay to the Department of Health of New York State the excess over $43.42 which it was actually paid during calendar 1976.

4. I have been advised by our counsel, Hancock, Estabrook, Ryan, Shove & Hust of Syracuse, New York (Bruce G. Soden of Counsel) that the Department of Health through its representative, announced in open court on December 21, 1976 that the rate which would be applicable to Plaza has been increased to $45.07 per patient day effective January 1, 1977. As the Administrator of Plaza, no official announcement has been made to Plaza. If this is an official rate of the Department of Health, it has certainly not been communicated.

5. The "patient day" cost to Plaza during calendar 1975 was $51.39 for which Medicaid reimbursement was made at the rate of $50.50. For calendar 1976, the patient day cost at Plaza was $51.76 for which Plaza was reimbursed only $50.50 since the Department of Health froze its rates. Plaza is advised that it must return the difference. Plaza has been able to recoup the difference between the Medicaid reimbursement and its actual costs by charging the remaining patients (20% of the total admitted) $56.00 per day and by making applications to the Department of Health for extra compensation based upon the extraordinary services rendered at Plaza.

Plaza has projected that, for calendar 1977, the patient day costs will be $53.44. These are our current costs. PLAZA HAS NEVER BEEN TOLD BY ANYONE THAT ITS COSTS WERE EXCESSIVE.

6. In my capacity as Hospital Administrator for Plaza, I have caused a projection to be made should Plaza be reimbursed at the rate of $43.42 for the Medicaid patients during the entire calendar year of 1977. Based upon our projected costs and the only promulgated rate available to me, I project a deficit to Plaza of $485,000.00 should we remain open during calendar 1977.

7. As of the end of December 1976, Plaza had accounts payable of $321,000.00 because of the difficulty securing the appropriate reimbursement from the Department of Health. Over 50% of these accounts payable were over 90 days old. These are accounts payable to Plaza's vendors who supply Plaza Nursing Home with drugs; food; all medical supplies; equipment; and utilities such as heat and light. So far the vendors have been patient as they understand the situation. We have paid them what we can. Being a not-for-profit corporation, Plaza has no reserves. At the present time our current cash payables greatly exceed our current cash receipts. We have no equity. Effectively, Plaza is bankrupt right now.

8. Because of the bizarre new regulations imposed by the Department of Health, Plaza cannot cut any service that it is now rendering without violating a code which, in turn, subjects Plaza to a $1,000.00 per day per violation penalty and a reduction in its rating. For instance, if Plaza were to be reduced in any category to merely "Good Federal" it would only receive 35% of the arbitrarily determined standard instead of the arbitrarily determined 60%. Plaza and many other nursing homes are caught in a situation where the Department of Health sets extremely high

standards and then refuses to provide adequate monies to pay for the maintenance of these standards.

9. The consensus of the Board of Directors of Plaza at the last meeting was that they would not continue to run a deficit. As I understand it, the Board of Directors will resign and return the facility to the New York State Department of Health to be run by it. It is extremely unlikely that it will continue Plaza. All the Medicaid patients (some 242 in Plaza) will be turned back to the Department of Social Services which is not equipped or ready for them (the Department doesn't have the beds or the facilities). The horrendous cost in human misery and human lives cannot be underestimated. The damages are irremediable.

Further, if Plaza were to close it is difficult to imagine that it could easily or ever secure the same staff and rise to the same level of efficiency and service.

10. I respectfully request the Court grant the injunction to halt this arbitrary and capricious action on the part of the New York Department of Health.

Edward A. Leone
Edward Leone

Subscribed and sworn to before
me this 26 day of January,
1977.

Bruce G. Soden
Notary Public

BRUCE G. SODEN
Notary Public, State of New York
Qualified in Onon. Co. No. 34-909-9550
My Commission Expires March 30, 1978

EXHIBIT I

STATE OF NEW YORK - DEPARTMENT OF HEALTH

HOSPITAL MEMORANDUM . . .

435

Series - 76-145
Date - 12/30/76

NH-44; HRF-44

SUBJECT: Residential Health Care Facility Rates of Payment for the January 1, 1977 - March 31, 1977 Portion of the 15 Month Rate Period January 1, 1976 - March 31, 1977

The attached schedules list the residential health care facility rates to be paid by governmental agencies for public charge patients from January 1, 1977 through March 31, 1977. These rates have been developed in accordance with Part 86 of the Commissioner of Health's Administrative Rules and Regulations.

The rates on the attached schedules are all-inclusive reimbursement rates for services rendered by the facilities and, therefore, no payments in addition to the rates are to be made to any facility.

These residential health care facility rates include an adjustment to the trend factor to reflect increased inflation for a 15 month rate period ending March 31, 1977.

Joseph M. Giglio (wpm)

Joseph M. Giglio
Deputy Commissioner
Division of Health Care Financing

Endorsement: Frank T. Cicero M.D.
Frank T. Cicero, M.D.
Second Deputy Commissioner

Attachments

Nursing Homes

Schedule of Rates

ion: WESTERN NEW YORK Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Allegany County		
ellsville Nursing Home	$29.35	B,E
Cattaraugus County		
St. Joseph's Manor	25.89	B,C
Salamanca Nursing Home	32.05	
Chautauqua County		
Fenton Park Nursing Home	31.65	B
erry Nursing Home Company, Inc	36.76	A,B,D
akeshore Nursing Home	35.64	A,B,D
Lutheran Retirement Home	34.92	B
Manor Oak Nursing Home	28.20	B,DE
Margaret-Anthony Nursing Home	26.87	
Erie County		
Abbey Nursing Home	24.33	
Abbott Manor Nursing Home	29.54	
Amherst Nursing & Convalescent Home	27.06	A,B,C,D
Aurora Park Nursing Home	34.30	B,C
Brothers of Mercy Nursing Home	42.06	A,B,C,D
Delaware Avenue Nursing Home	27.99	C,D
Downtown Nursing Home	41.56	A,B,D,E
Fiddlers Green Manor	26.78	B,C
Furgala Nursing Home	37.68	A,B,C,F
Georgian Court Nursing Home	30.91	
Grand Island Manor Nursing Home	40.48	A,B,C
Jennie B. Richmond Chaffee Nursing Home	37.53	B
Manhattan Manor Nursing Home	29.65	
Manor Oak Nursing Home	27.41	
Nazareth Nursing Home	37.52	A,B,C,D
Niagara Frontier Nursing Home	41.39	B,C

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E Physician Services
Dental Services
G- All Inclusive

437

Nursing Homes

Schedule of Rates

Region: WESTERN NEW YORK CON'T

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Erie County		
Niagara Lutheran Home	$29.94	B,C,D
Orchard Park Nursing Home	28.98	C
Presbyterian Homes of Western New York	32.25	
Rosa Coplon Jewish Home and Infirmary	44.40	A,B,C,F
Seneca Manor Nursing Home	32.98	
Sheridan Manor Nursing Home	32.88	B,C,D
St. Francis Home of Williamsville	28.00	A
St. George Nursing Home	24.44	
Tri-Del Nursing Center	32.57	B,C,D
24 Rhode Island Street Nursing Home	37.73	
Wheel Chair Home	27.61	
Genesee County		
Batavia Nursing Home	32.58	A,B
St. Luke's Manor	28.47	
Niagara County		
Briody Nursing Home	31.97	A,B,C
Deveaux Manor Nursing Home	30.80	A,B,D
Fairchild Manor Nursing Home	29.32	A,B,C,D
Newfane Health Facility	57.23 (+36.17)	A,B,C,D
Niagara Falls Memorial Nursing Home	49.93	G
Odd Fellows and Rebekah Nursing Home	37.00	
St. Clare's Manor of Lockport	29.28	B,C,F
St. Mary's Manor	36.28	A,B,C,D
United Church Colony Home	32.28	A, B,C
Orleans County		
Orchard Manor Nursing Home	31.21	
Wyoming County		
EastSide Nursing Home	32.95	A,B,C
Manor Oak Nursing Home	27.80	B

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

Schedule of Rates

on: WESTERN NEW YORK CON'T Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
on-Occupant Services (Subchaper H)		
rothers of Mercy (Erie Co.)	$11.29	
rand Island Manor (Erie Co.)	11.52	P.T.only
t. Mary's Manor (Niagara Co.)	11.67	

- Prescription Drugs
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Physician Services
- Dental Services
- All Inclusive

Nursing Homes
Schedule of Rates

439

Region: ROCHESTER REGION

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Chemung County		
Elcor Nursing Home	$31.94	C,E
Livingston County		
Avon Nursing Home	29.86	
Conesus Lake Nursing Home	29.54	
Monroe County		
Aberdeen Nursing Home	26.83	
Alaimo Nursing Home	29.62	
Beechwood Sanitarium	37.10	A,B,C,D,F
Blossom Nursing Home	40.62	B,C,E,F
Brightonian Nursing Home	30.73	C
Church Home of the Protestant Episcopal Church	46.41	B,C,E
Cobbs Hill Nursing Home	39.60	B,D
Crest Manor Nursing Home	39.04	B,C
Cupola Nursing Home	32.06	
Fairport Baptist Home Infirmary	38.84	A,B,C,E,F
Flower City Nursing Home	27.56	
Goodman Gardens Nursing Home	39.61	
Hamilton Manor Nursing Home	19.78	
Hill Haven Nursing Home	37.35	F
Hurlbut Nursing Home	30.64	
Jewish Home and Infirmary	38.83	A,B,C,D,F
Lakeshore Nursing Home	33.85	B
Latta Road Nursing Home	23.03	
Latta Road "A" Nursing Home	19.93	
Maplewood Sanitarium	38.31 (27.18)	B,C
Nortonian Nursing Home	41.56	B,E
Park Ridge Nursing Home	49.27	G
Penfield Nursing Home	30.58	
Rochester Friendly Home	35.91	A,B,C,D,E,F

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

Schedule of Rates

440

gion: ROCHESTER REGION CON'T Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Monroe County		
St. Ann's Home for the Aged............	$38.08	G
St. John's Nursing Home............	50.94	G
Wedgewood Nursing Home..................	28.68	
Westgate Nursing Home..................	37.26	B,C
Woodside Manor Nursing Home............	33.29	
Ontario County		
Elm Manor Nursing Home..................	30.35	
Geneva General Hospital Nursing Home....	41.87	A,B,C,D,E
Thompson Nursing Home..................	45.32	A,B,C,E
eneca County		
neca Nursing Home and HRF............	31.85	B
Steuben County		
Hornell Nursing Home..................	30.97	B
Wayne County		
Blossom View Nursing Home..............	34.26	
Newark Manor Nursing Home..............	29.92	
Yates County		
Penn Yan Nursing Home................	36.35	A,B,C
Non-occupant Services (Subchapter H) St. John's Nursing Home Co. (Monroe Co.).	13.80	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
- Speech Therapy
Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

Schedule of Rates

447

Region: CENTRAL NEW YORK

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Broome County		
Elizabeth Church Manor Infirmary	$25.35	
Endicott Nursing Home	32.93	A,B
Good Shepherd-Fairview Home, Inc	30.21	A
Rivermede Manor Nursing Home	34.14	A,B
Susquehanna Nursing Home and HRF	35.36	B,C,D
Vestal Nursing Home	33.07	B,E
Cayuga County		
Auburn Nursing Home	29.58	B
Howd Nursing Home	27.41	
Maxwell Nursing Home	21.74	
Mercy Health & Rehabilitation Center	38.23	A,B,C,D
Chenango County		
Chase Memorial Nursing Home	32.45	B,C,D
Valley View Manor Nursing Home	29.37	B,C
Cortland County		
Cortland Nursing Home	32.04	B,E
Highgate Manor of Cortland	34.19	B,C,F
Herkimer County		
Folts Home	25.23	B,E
Mohawk Valley Nursing Home	44.62	A,B,E
Van Allen Nursing Home	35.03	B,C,F
Jefferson County		
Green Briar Nursing Home	32.03	A
Samaritan-Keep Nursing Home	33.24	A,B,C,D,F

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

442

Schedule of Rates

Region: CENTRAL NEW YORK CON'T

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Madison County		
Stonehedge-Chittenango Nursing Home and HRF	$35.29	
Oneida County		
Charles T. Sitrin Home	38.80	B,E
Eastern Star Home and Infirmary	31.42	A,B,C,E,F
Eden Park Nursing Home	34.54	B
Genesee Nursing Home	28.65	B,C
Harding Nursing Home	31.19	B,C
Martin Luther Nursing Home	35.70	B,C
Masonic Home and Health Facility	35.54	A,B,D,E
Presbyterian Home of Central NY	35.49	B,C,D
Rome Nursing Home	33.09	B,E
St. Joseph's Nursing Home Co. of Utica	40.58	A,B,C,D
Stonehedge Nursing Home	31.23	B
Sunset Nursing Home	26.24	B,C,D
Onondaga County		
Castle Rest Nursing Home	36.32	B,D
Hill Haven Nursing Home	35.71	B,C
James Square Nursing Home	36.31	B
Jewish Home of Central NewYork	34.69	A,B,D,E
Loretto Geriatric Center	50.10 ✓	G
Minoa Nursing Home	34.45	A,B,C,D
Plaza Nursing Home	45.07	G
St.Camillus Nursing Home	38.82	A,B,C,D,F
Sunnyside Nursing Home	36.54	A,B,C,F
Oswego County		
Harr-Wood Nursing Home	36.76	B,E
Hillcrest Nursing Home	33.97	B,E
Pontiac Nursing Home	31.48	B,D,E
St. Lawrence County		
Cedars Nursing Home	28.78	
Gouverneur Nursing Home	37.45	B
Highland Nursing Home	26.76	B,C,D
Moongate Nursing Home	35.45	B

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Schedule of Rates

Region: CENTRAL NEW YORK CON'T Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
St. Lawrence County		
Potsdam Nursing Home	$26.87	B,C
St. Joseph's Home	25.83	B,C,D
St. Regis Nursing Home	30.77	
United Helpers Nursing Home	30.49	B,C
Tioga County		
Riverview Manor Nursing Home	26.06	D
Tioga Nursing Home	38.68	A,B
Tompkins County		
Grand Lodge IOOF Home and Orphanage	28.18	A
Lakeside Nursing Home	37.76	B,D
Oak Hill Manor Nursing Home	31.04	
Reconstruction Home	31.20	A,B,C,D
Non-occupant Services (Subchapter H)		
Charles T. Sitrin Home (Oneida Co.)	10.37	
Loretto Rest, Inc. (Onondaga Co.)	13.92	
St. Camillus Nursing Home Co. Inc (Onondaga Co.)	11.40	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

444

Schedule of Rates

ion: NORTHEASTERN NEW YORK Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
lbany County		
Child's Nursing Home....................	$42.38	A,B
Daughters of Sarah Nursing Home..........	46.43	A,B,D,E
Eden Park Nursing Home..................	34.59	B,C,D
Guilderland Center Nursing Home..........	28.76	
ary and Alice Ford Nursing Home.........	46.97	B
St. Margaret's House&Hospital for Babies.	35.75	A,B
University Heights Nursing Home..........	45.03	A,B,C,D
illa Mary Immaculate....................	32.36	B
r Lady of Hope Residence................	34.17	B,F
inton County		
edar Hedge Nursing Home.................	25.48	
eadowbrook Nursing Home.................	35.17	
Sacred Heart Home.......................	30.82	B
Columbia County		
Adventist Nursing Home..................	37.90	A,B,D,E,F
Barnwell Nursing Home...................	38.20	A,B
Eden Park Nursing Home..................	31.95	
ssex County		
ses Ludington Hospital..................	42.39	A,B,C,E
Uihlein Mercy Center....................	46.56	A,B,D,E,F
Fulton County		
Gloversville Nursing Home................	49.63	A,B,D
Wells Nursing Home......................	39.22	A,B,E
Greene County		
Eden Park Nursing Home..................	31.03	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
Physician Services
Dental Services
G- All Inclusive

Nursing Homes

445

Schedule of Rates

Region: NORTHEASTERN NEW YORK CON'T

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Montgomery County		
Mt. Loretto Convalescent&Rest Home	$27.77	B
Palatine Nursing Home	20.53	
Otsego County		
Oneonta Nursing Home	30.31	
Rensselaer County		
Eden Park Nursing Home	28.83	
Hallmark Nursing Home	32.29	B,D
Highgate Manor	38.11	B,C,D
Hoosick Falls Health Center	26.62	
Resurrection Rest	24.78	
Saratoga County		
Wesley Nursing Home	45.70	A,B,D,E
Schenectady County		
Hallmark Nursing Home	36.08	B,C,D
Kingsway Arms Nursing Center	37.11	
Silver Haven Nursing Home	33.87	
Schoharie County		
Eden Park Nursing Home	31.70	A,B,C
Warren County		
Adirondack Tri-County Nursing Home	38.57	B
Eden Park Nursing Home	35.38	B,C,E
Hallmark Nursing Center	31.53	
Washington County		
Fort Hudson Nursing Home	37.35	B,E
Indian River Nursing Home	27.75	B,D,E

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E-Physician Serv
F-Dental Services
G-All Inclusive

NURSING HOMES

Schedule of Rates

Region: NORTHERN METROPOLITAN REGION Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
utchess County		
ntral Dutchess Nursing Home	$35.99	C
en Park Nursing Home	43.46	A, B, E
rncliff Nursing Home	45.75	G
Hyde Park Nursing Home	43.61	A, B, E, F
Lovely Hill Nursing Home	37.69	B
Northeastern Conference Nursing Home	40.59	B, D, F
Orange County		
rle Nursing Home	26.44	
Jones and Martin Nursing Home	23.79	E
Montgomery Nursing Home	30.64	A, C
St. Teresa's Nursing Home	41.71	B, C, D, E, F
Sylcox Nursing Home	40.31	B
nam County		
Nursing Home	35.05	
Rockland County		
Elmwood Manor Nursing Home	51.16	A, B
Hillcrest Nursing Home	41.38	A, B
Maple Leaf Nursing Home	45.10	A, B
ack Manor Nursing Home	41.31	A, B
apo Manor Nursing Home	40.16	A, B, C
verside Nursing Home	40.73	A, B
stoy Foundation Nursing Home	45.63	A, B, D, E
llivan County		
Roscoe Community Nursing Home	40.76	B, C, D, F
Walnut Mountain Nursing Home	40.24	
Ulster County		
Hadler's Nursing Home	24.38	
Hudson Valley Nursing Home	32.60	B
Hutton Nursing Home	33.88	B, C,
New Paltz Nursing Home	34.25	

A- Prescription Drugs
hysical Therapy
-Occupational Therapy
D-Speech Therapy
E-Physician Services
F-Dental Services

G-All Inclusive

NURSING HOMES 447
Schedule of Rates

Region: NORTHERN METROPOLITAN REGION Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Westchester County		
Asthmatic Children's Foundation	$29.63	E
Bayberry Nursing Home	31.76	
Bethel Nursing Home	50.90	
Brandywine Nursing Home	60.27	A
Briar Crest Nursing Home	30.97	
Cedar Manor Nursing Home	42.34	
Centre Manor Nursing Home	34.37	
Cortlandt Health Care Center	42.66	A
Dumont Nursing Home	44.24	
Home for Aged Blind	40.32✓	A,B,E,F
Howe Avenue Nursing Home	55.09	A,B,C,D
Hudson View Nursing Home	54.16	A
King Street Home, Inc	47.13	
Marrs Nursing Home	39.95	B,C
New Rochelle Nursing Home	43.84	B,F
Nursing Home & Extended Care Facility of White Plains	39.03	B,C,E
Port Chester Nursing Home	41.09	
St. Cabrini Nursing Home	57.29	A,B
Sans Souci Nursing Home	44.32	B
Sarah R. Newman Nursing Home	46.42	B,C,E
Shalom Nursing Home	48.95	A,B
Sky View Haven Nursing Home	49.08	B
Somers Manor Nursing Home	42.54	B
SprainBrook Manor Nursing Home	46.93	
Tarrytown Hall Nursing Home	43.58	A,B,C
Tibbits Health Care Facility	44.98	
United Home for Aged Hebrews	45.48	A,B,C,E,F
United Nursing Home for Aged, Inc	51.96	G
Wartburg Nursing Home	40.81	A,B,E,F
Waterview Hills Nursing Home	42.67	B,C,D
Westledge Nursing Home	46.48	B
White Plains Center for Nursing Care	38.96	B,C
Woodland Nursing Home	46.76	C

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES
Schedule of Rates

448

Region: LONG ISLAND

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Nassau County		
Bayview Nursing Home	$44.43	B
Belair Nursing Home	39.60	
Central Island Nursing Home	41.17	C
Daleview Nursing Home	44.63	B
East Rockaway Nursing Home	48.39	B
Five Towns Nursing Home	39.29	A,B,E
Franklin Park Nursing Home	42.99	B
Glengariff Nursing Home	43.20	B
Grace Plaza of Great Neck	42.17	
Long Beach Grandell	41.75	B
Long Beach Memorial Nursing Home, Inc.	62.48	A,B,C
Long Island Tides Nursing Home	44.19	B
Mayfair Nursing Home	45.28	
Montclair Nursing Home	43.25	
Nassau Nursing Home	36.52	B
Park View Nursing Home	41.47	C
Rockville Nursing Center	41.72	B
Sands Point Nursing Home	37.21	C
South Shore Nursing Home	44.84	
Sun Harbor Manor Nursing Home	45.61	B
United Presbyterian Home at Syosset	42.98	A,B,C
Woodbury Nursing Home	44.11	
Wedgewood Nursing Home	42.97	
Suffolk County		
Berkshire Nursing Home	40.20	
Birchwood Nursing Home	50.55	B,C
Carillon House Nursing Home	42.24	
Cedar Lodge Nursing Home	34.38	
Consolation Nursing Home	52.42	A,B,C,D
Eastern Suffolk Nursing Home	37.38	
Hilaire Farm Nursing Home	40.22	
Little Flower Nursing Home and HRF	42.74	B
Oak Hollow Nursing Center	47.85	A,B,C
Patchogue Nursing Center	40.38	B,C
Port Jefferson Nursing Home	44.96	B
Riverhead Nursing Home	42.51	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES
Schedule of Rates

Period: 1/1/77-3/31/77

Region: LONG ISLAND

County Name of Facility	Daily Rate	Services Included in Rate
Suffolk County (con't)		
Ross Nursing Home	$41.71	B
St. James Nursing Home	46.71	A,B,C,D
St. Johnland Nursing Home, Inc.	50.60	G
Sayville Nursing Home	46.55	B,C,D,F
Smithtown Nursing Home	37.83	B,C,D
Sunrest Nursing Home	38.57	B,E
Sunrise Manor Nursing Home	43.73	B,D
Todd Nursing Home	44.26	B,C
Westhampton Nursing Home	34.30	
Woodhaven Manor Nursing Home and HRF	46.88	B
Non-occupation Services (Subchapter H) Long Beach Memorial Nursing Home, Inc. (Nassau County)	21.87	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES
Schedule of Rates

Region: NEW YORK CITY

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Bronx County		
Astor Gardens Nursing Home	$37.68	B
Bainbridge Nursing Home	44.66	A,B
Beth Abraham Hospital	61.93	A,B,C,D,E
Bruckner Nursing Home	45.30	A,B,C,D
Concourse Nursing Home	54.24	G
Daughters of Jacob Nursing Home	68.14	G
Eastchester Park Nursing Home	40.87	A,B,C
Fairfield Nursing Home	45.40	
Fieldston Lodge Nursing Home	45.73	B
Frances Schervier Home and Hospital	45.30	A,B,C,D,E
Hebrew Home for the Aged	63.17	A,B,C,E
Hebrew Hospital for Chronic Sick	65.82	G
House of Holy Comforter	44.40	A,B,C,E
Kings Harbor Care Center	53.22	A,B,C
Kings Harbor Manor Nursing Home	45.16	A,B,C,D
Kings Terrace Nursing Home	48.09	B
Kingsbridge Heights Nursing Home	51.73	A,B,C
Laconia Nursing Home	47.16	A,B,C
Methodist Church Home for the Aged	41.96	A,B,E
Morningside House Nursing Home	58.28	A,B,C,E,F
Morris Park Nursing Home	47.52	B,E
Mosholu Parkway Nursing Home	44.51	
Notre Dame Home for the Aged Poor	31.04	A,B,C
Palisade Nursing Home	75.02	A,B,C,E
Parkview Nursing Home	46.01	A,B,C
Pelham Parkway Nursing Home	46.29	A,B,C,D
Providence Rest Home for the Aged	46.10	A,B,C,E,F
Riverdale Nursing Home	45.46	B
Rofay Nursing Home	46.15	B
St. Patrick's Home for Aged and Infirmary	43.38	A,B,C,F
Split Rock Nursing Home	41.19	A,B
United Odd Fellows and Rebekah Home	41.75	A,B,E,F
University Nursing Home	38.21	B,C
W.K. Nursing Home	71.34	G
Wayne Health Related Facility	49.91	G
West Road Nursing Home	70.65	G
White Plains Nursing Home	41.51	A,B
Williamsbridge Manor Nursing Home	43.22	B,C
Workman's Circle Home and Infirmary	45.52	A,B,C,E,F
Non-occupant Services (Subchapter H)		
W.K. Nursing Home	20.88	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

451

NURSING HOMES

Schedule of Rates

Region: NEW YORK CITY

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Kings County		
Augustana Lutheran Home for Aged	$37.25	A,B,F
Baptist Home of Brooklyn	39.66	A,C,E,F
Belt Parkway Nursing Home	39.16	B
Brookdale Hospital Center Nursing Home	62.28	B,C,E
Brooklyn Methodist Church Home	46.54	G
Carlton Nursing Home	39.09	B
Caton Park Nursing Home	48.38	B
Cobble Hill Nursing Home	41.[illegible]4	A,B,C
Concord Nursing Home	49.91	G
Crown Nursing Home	40.79	
Dover Nursing Home	37.95	
Farragut Nursing Home	36.86	B
Greenpark Care Center	53.16	B
Haym Salomon Home for the Aged	42.17	G
Holy Family Home 1601 8th Ave	34.54	A,B,C,E
Holy Family Home 1740 84th St	50.51	A,B,C,E
Ingersoll Nursing Home	40.17	
Lemberg Home and Geriatric Institute	42.01	A,B,C,E,F
Madonna Residence	39.70	A,B,C,E,F
Menorah Home and Hospital for Aged and Infirmary	54.80	A,B,C,D,E
M.J.G.	71.05	G
New York Congregational Home	38.01	A,C,E,F
Norwegian Christian Home and Health Center	45.85	G
Oxford Nursing Home	37.54	B
Palm Gardens Nursing Home	49.51	B,C,D
Palm Tree Nursing Home	42.97	B,C,D
Prospect Park Nursing Home	39.61	
Rutland Nursing Home	88.35	G
Sea Crest Health Care Center	42.19	A,B
Sephardic Home for Aged	50.59	A,B,C,E,F
Sheepshead Nursing Home	49.58	A,B
Shore View Nursing Home	42.15	A,B
Wartburg Nursing Home	54.32	A,B,E,F
Willoughby Nursing Home	41.87	B
CABS Nursing Home Company	49.56	A, B,C,E

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Schedule of Rates 452

gion: NEW YORK CITY Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
New York County		
Amsterdam House	51.99	G
American Nursing Home	$46.10	B,C
Bialystoker Home for the Aged	43.14	A,B,C,E
DeWitt Nursing Home	54.26	A,B,C
Florence Nightingale Nursing Home	52.64	A,B,D
Fort Tryon Nursing Home	47.95	A,B,C
Greater Harlem Nursing Home Co. Inc	54.64	G
Home of the Sages of Israel	39.56	A,B,E
Isabella Home Nursing Home	71.15	G
Jewish Home and Hospital for the Aged	64.55 -	A,B,C,E
Mary Manning Walsh Nursing Home	55.42	A,B,C,E,F
Mt. Carmel Home for the Aged	37.06	A,B,C,E
Park Crescent Nursing Home	43.14	B,C,D
Sangers Nursing Home	35.41	
Village Nursing Home	38.34	
Queens County		
Bayside Gardens Nursing Home	39.07	B
Bridgeview Nursing Home	42.33	B,C
Brookhaven Beach Nursing Home 17-11 Brrokhaven Ave.	46.77	A,B
Brookhaven Beach Health Related Facility 250 Beach 17th Street	38.82	A,B
Clearview Nursing Home	40.48	
Cliffside Nursing Home	46.15	B
College Nursing Home	46.17	B
Dry Harbor Nursing Home	43.46	A,B,C,D
Fairview Nursing Home	46.59	B
Far Rockaway Nursing Home	43.01	B
Flushing Manor Care Center	48.69	B,C,D
Flushing Manor Nursing Home	44.49	B,C
Forest Hills Nursing Home	43.02	B,C
Forest View Nursing Home	45.84	A,B,C
Franklin Nursing Home	50.37	A,B,C,D
Hillside Manor	51.47	B,C,D
Hollis Park Gardens Nursing Home	47.09	B
Holliswood Care Center	47.05	A,B,D
Jamacia Hospital Nursing Home	63.62	A,B,C,E
Jewish Insitute for Geriatric Care	73.28	G
Lawrence Nursing Home	52.16	B,C,E
Little Neck Nursing Home	49.09	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

Schedule of Rates 453

Period: 1/1/77-3/31/77

Region: NEW YORK CITY CON'T

County Name of Facility	Daily Rate	Services Included in Rate
Queens County (con't.)		
Long Island Nursing Home	$39.89	B,D
Lyden Nursing Home	47.32	B
Margaret Tietz Center for Nursing Care	53.20	G
Meadow Park Nursing Home	43.46	B
Midway Nursing Home	46.48	A,B,C,D
New Glen Oaks Nursing Home	47.58	
Oceanview Nursing Home	40.04	
Ozanam Hall of Queens Nursing Home	61.00	A,B,C,E,F
Park Nursing Home	44.53	B
Peninsula General Nursing Home	72.73	A,B,C,D,E
Promenade Nursing Home	42.50	B,D
Queen Of Peace Residence	41.17	A,B,C,E
Queens-Nassau Nursing Home	46.08	A,B,C
Rego Park Nursing Home	50.11	A,E
Resort Nursing Home	49.84	A,B,C
St. Mary's Hospital for Children	61.94	G
Surfside Nursing Home	42.52	B,D
Van Doren Nursing Home	46.17	B
Windsor Park Nursing Home	45.48	
Woodcrest Nursing Home	44.81	B
Woodhull Care Center	45.12	A,B,C
Rockaway Care Center	51.26	G
Richmond County		
Carmel Richmond Nursing Home	52.58	A,B,E,F
Clove Lakes Nursing Home	44.16	B,C
Eger Nursing Home	65.40	G
Golden Gate Health Care Center	43.79	A,B,C,D
Lily Pond Nursing Home	36.71	
New Brighton Manor Care Center	44.75	A,B,C
New Vanderbilt Nursing Home	44.62	B
Silver Lake Nursing Home	43.01	
Verrazano Nursing Home	40.50	B,C

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

HEALTH RELATED FACILITIES

454

Schedule of Rates

Region: WESTERN NEW YORK

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Cattaraugus County		
Salamanca Nursing Home	$24.97	
Chautauqua County		
Gerry Nursing Home Company	24.11	A, B, D
Lutheran Retirement Home	21.36	
Presbyterian Homes of Western NY	24.75	
Erie County		
Aurora Park Nursing Home	23.40	B, C
Brothers of Mercy Nursing Home	27.41	A, B, C, D
Jennie B. Richmond Chaffee Nursing Home	31.41	B
Manhattan Manor Nursing Home	22.28	
Nazareth Health Related Facility	23.52	A, B
Niagara Frontier Methodist Home	14.32	B, C
Orchard Park Health Related Facility	22.95	C
Presbyterian Homes of Western NY	19.91	
Rosa Coplon Jewish Home and Infirmary	20.95	A, B, C, F
St. Francis Home of Williamsville	14.25	A
Seneca Manor Health Related Facility	23.03	
Tri-Del Nursing Center	28.88	B, C, D
24 Rhode Island Street Nursing Home	28.22	
Wheel Chair Home	20.96	
Williamsville View Manor	23.34	B, C, D, E
Niagara County		
Newfane Health Related Facility	22.74	A, B, C, D
Odd Fellows and Rebekah Nursing Home	27.70	
Niagara Geriatric Center	23.70	
Orleans County		
Orchard Manor Nursing Home and HRF	20.65	

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES

455

Schedule of Rates

gion: ROCHESTER REGION

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Monroe County		
Church Home of Protestant Episcopal Church...	$13.97	B, C, E
Fairport Baptist Home..........................	20.23	A, B, C, E, F
Goodman Gardens Nursing Home.................	24.91	
Hill Haven Health Related Facility...........	23.66	F
Jewish Home and Infirmary....................	23.15	A, B, C, D, F
Rochester Friendly Home......................	24.35	A, B, C, E, F
Rochester Methodist Home.....................	13.65	
St. Ann's Nursing Home (The Heritage)........	22.60	G
St. John's Home for the Aging................	22.17	A, B, C, F
St. John's Nursing Home......................	32.31	G
Ontario County		
Geneva General Hospital Nursing Home.........	29.50	A, B, C, D, E
Thompson Nursing Home, Inc...................	25.15	A, B, C, E
Seneca County		
Seneca Nursing Home and HRF..................	24.79	B
Steuben County		
Hornell Nursing Home and HRF.................	24.37	

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

Region: CENTRAL NEW YORK REGION | Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Broome County		
Elizabeth Church Manor Infirmary	$11.55	
Endicott Nursing Home	27.71	A, B
Good Shepherd-Fairview Home	17.42	A
Rivermede Manor Nursing Home	26.66	A, B
Susquehanna Nursing Home and HRF	22.54	B, C, D
Cayuga County		
Mercy Health & Rehabilitation Center	28.83	A,B,C,D
Chenango County		
Chase Memorial Nursing Home	23.72	B, C, D
Cortland County		
Highgate Manor of Cortland	22.81	B, C, F
Herkimer County		
Van Allen Nursing Home and HRF	27.97	B, C, F
Jefferson County		
Samaritan-Keep Nursing Home	28.00	A, B, C, D, F
Madison County		
Stonehedge-Chittenango Nursing Home & HRF	25.75	

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

on: CENTRAL NEW YORK REGION

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
neida County		
etsy Ross Lodge HRF	$25.34	
harles T. Sitrin Nursing Home	28.26	B, E
astern Star Home and Infirmary	23.47	A, B, C, E, F
den Park Nursing Home	21.24	B
arding Nursing Home and HRF	23.84	B, C
RF of Rome (Bethany House)	25.44	B
artin Luther Nursing Home	25.71	B, C
asonic Home and Health Facility	17.44	A, B, D, E
Onondaga County		
Loretto Geriatric Center	32.73	G
Syracuse Home Association	21.00	A
Oswego County		
Hillcrest Nursing Home	22.19	B, E
St. Luke's Nursing Home	25.11	A
St. Lawrence County		
Moongate Nursing Home and HRF	25.61	B
St. Regis Nursing Home	21.08	
United Helpers Nursing Home	22.83	B, C, D
Tompkins County		
Grand Lodge IOOF and Orphanage of NY	17.87	A
Lakeside Nursing Home	26.35	B, D, F

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

BEST COPY AVAILABLE

HEALTH RELATED FACILITIES
Schedule of Rates

Region: NORTHEASTERN NEW YORK REGION Period; 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Albany County		
Good Samaritan Nursing Home	$26.68	A
Teresian House Nursing Home	31.24	A, B, D
Our Lady of Hope Residence	22.61	B, F
Clinton County		
Meadowbrook Nursing Home	26.35	
Columbia County		
Adventist Nursing Home	26.81	A, B, D, E, F
Barnwell Nursing Home	22.58	A, B
Greene County		
Eden Park Nursing Home	26.40	
Rensselaer County		
Highgate Manor	26.70	B, C, D
Leisure Arms	19.71	
Resurrection Rest	19.65	
Rosewood Gardens HRF	28.14	
Saratoga County		
Wesley Nursing Home	34.41	A, B, D,E

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates 459

ion: NORTHEASTERN NEW YORK REGION (con't.) Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Schenectady County		
ings Way Arms Nursing Center	$24.40	
Schoharie County		
Eden Park Nursing Home	23.38	A, B, C
arren County		
Eden Park Nursing Home	24.66	B, C, E
ashington County		
Indian River HRF	17.59	B, D, E
Fort Hudson Nursing Home	26.37	B, E

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

460

Region: NORTHERN METROPOLITAN REGION   Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Dutchess County		
Eden Park Nursing Home	$28.96	A, B, E
Ferncliff Nursing Home	34.33	G
Fishkill Health Related Center	24.88	B
Lovely Hill Nursing Home	26.46	B
Orange County		
Sylcox Nursing Home	28.25	B
Rockland County		
Friedwald House	30.31	A, B
Ramapo Manor Health Related Facility	28.58	A, B, C
Sullivan County		
Walnut Mountain Health Related Facility	24.09	
Ulster County		
Hudson Valley Nursing Center	24.31	B

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES

461

Schedule of Rates

Region: NORTHERN METROPOLITAN REGION (con't.) Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Westchester County		
Bethel Methodist Home	$19.41	
Cortlandt Health Care Center	31.30	A
Home for the Aged Blind	26.26	A, B, E, F
King Street Health Related Facility	34.47	
Providence Rest	27.01	A, B, C, E, F
Sarah R. Neuman Nursing Home HRF	37.55	B, D
SkyView Haven Health Related Facility	33.03	B
Somers Manor Nursing Home and HRF	28.01	C
Swiss Home for the Aged	26.55	
Tarrytown Hall Health Related Facility	31.80	A, B, C
Tibbets Health Care Facility	30.98	
United Home for Aged Hebrews	22.50	A, B, C, E, F
Victoria Home for Aged British Men and Women.	17.82	
Wartburg Intermediate Care Facility	24.22	A, B, E, F

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

Region: LONG ISLAND REGION

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Nassau County		
Daleview Manor	$28.37	B
Five Towns Nursing Home HRF	23.88	A
Five Towns HRF - Cerebral Palsy Unit	40.42	A
Forest Manor	24.82	
Glengariff Nursing Home	29.49	B
Grace Plaza of Great Neck	27.37	
Long Beach Grandell	28.84	B
Long Beach Memorial Nursing Home	40.26	A, B, C
Rockville Residence Manor	31.30	
Sun Harbor Health Related Facility	31.58	B
United Presbyterian Home at Syosset	24.73	A, B, C
Woodbury East Health Related Facility	26.54	
Suffolk County		
Birchwood Nursing Home	36.35	
Carillon House Health Related Facility	34.64	
Consolation Nursing Home	33.61	A, B, C, D
Crest Hall Health Related Facility	30.68	A, B, C, F
Little Flower Nursing Home and HRF	33.19	B
Peconic Nursing and Adult Center	25.72	
Port Jefferson Nursing Home and HRF	31.64	B
Riverhead Nursing Home HRF	25.41	
St. James Plaza Health Related Facility	29.66	
St. Johnland Nursing Home	33.52	G
Smithtown Nursing Home	27.31	B, C, D
Sunrest Health Related Facility	32.04	
Woodhaven Manor Nursing Home and HRF	32.51	B

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

464

EXHIBIT J

Nursing Homes

Schedule of Rates

465

Region: CENTRAL NEW YORK

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Broome County		
Elizabeth Church Manor Infirmary	$25.35	
Endicott Nursing Home	32.93	A,B
Good Shepherd-Fairview Home, Inc	30.21	A
Rivermede Manor Nursing Home	34.14	A,B
Susquehanna Nursing Home and HRF	35.36	B,C,D
Vestal Nursing Home	33.07	B,E
Cayuga County		
Auburn Nursing Home	29.58	B
Howd Nursing Home	27.41	
Maxwell Nursing Home	21.74	
Mercy Health & Rehabilitation Center	38.23	A,B,C,D
Chenango County		
Chase Memorial Nursing Home	32.45	B,C,D
Valley View Manor Nursing Home	29.37	B,C
Cortland County		
Cortland Nursing Home	32.04	B,E
Highgate Manor of Cortland	34.19	B,C,F
Herkimer County		
Folts Home	25.23	B,E
Mohawk Valley Nursing Home	44.62	A,B,E
Van Allen Nursing Home	35.03	B,C,F
Jefferson County		
Green Briar Nursing Home	32.03	A
Samaritan-Keep Nursing Home	33.24	A,B,C,D,F

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes 466

Schedule of Rates

Region: CENTRAL NEW YORK CON'T

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Madison County		
Stonehedge-Chittenango Nursing Home and HRF	$35.29	
neida County		
Charles T. Sitrin Home	38.80	B,E
Eastern Star Home and Infirmary	31.42	A,B,C,E,F
Eden Park Nursing Home	34.54	B
enesee Nursing Home	28.65	B,C
rding Nursing Home	31.19	B,C
tin Luther Nursing Home	35.70	B,C
sonic Home and Health Facility	35.54	A,B,D,E
sbyterian Home of Central NY	35.49	B,C,D
Nursing Home	33.09	B,E
Joseph's Nursing Home Co. of Utica	40.58	A,B,C,D
onehedge Nursing Home	31.23	B
unset Nursing Home	26.24	B,C,D
Onondaga County		
Castle Rest Nursing Home	36.32	B,D
Hill Haven Nursing Home	35.71	B,C
James Square Nursing Home	36.31	B
Jewish Home of Central NewYork	34.69	A,B,D,E
Loretto Geriatric Center	50.10 ✓	G
Minoa Nursing Home	34.45	A,B,C,D
laza Nursing Home	45.07	G
.Camillus Nursing Home	38.82	A,B,C,D,F
Sunnyside Nursing Home	36.54	A,B,C,F
Oswego County		
Harr-Wood Nursing Home	36.76	B,E
Hillcrest Nursing Home	33.97	B,E
Pontiac Nursing Home	31.48	B,D,E
St. Lawrence County		
Cedars Nursing Home	28.78	
ouverneur Nursing Home	37.45	B
ghland Nursing Home	26.76	B,C,D
Moongate Nursing Home	35.45	B

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
F- Dental Services
G- All Inclusive

Region: CENTRAL NEW YORK CON'T
Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
St. Lawrence County		
Potsdam Nursing Home	$26.87	B,C
St. Joseph's Home	25.83	B,C,D
St. Regis Nursing Home	30.77	
United Helpers Nursing Home	30.49	B,C
Tioga County		
Riverview Manor Nursing Home	26.06	D
Tioga Nursing Home	38.68	A,B
Tompkins County		
Grand Lodge IOOF Home and Orphanage	28.18	A
Lakeside Nursing Home	37.76	B,D
Oak Hill Manor Nursing Home	31.04	
Reconstruction Home	31.20	A,B,C,D
Non-occupant Services (Subchapter H)		
Charles T. Sitrin Home (Oneida Co.)	10.37	
Loretto Rest, Inc. (Onondaga Co.)	13.92	
St. Camillus Nursing Home Co. Inc (Onondaga Co.)	11.40	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Nursing Homes

Schedule of Rates

ion: NORTHEASTERN NEW YORK Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
lbany County		
Child's Nursing Home..........................	$42.38	A,B
Daughters of Sarah Nursing Home..........	46.43	A,B,D,E
Eden Park Nursing Home.....................	34.59	B,C,D
Guilderland Center Nursing Home..........	28.76	
Mary and Alice Ford Nursing Home.........	46.97	B
St. Margaret's House&Hospital for Babies.	35.75	A,B
University Heights Nursing Home..........	45.03	A,B,C,D
Villa Mary Immaculate........................	32.36	B
r Lady of Hope Residence.....................	34.17	B,F
nton County		
dar Hedge Nursing Home....................	25.48	
eadowbrook Nursing Home..................	35.17	
acred Heart Home............................	30.82	B
Columbia County		
Adventist Nursing Home.....................	37.90	A,B,D,E,F
arnwell Nursing Home.......................	38.20	A,B
Eden Park Nursing Home.....................	31.95	
Essex County		
Moses Ludington Hospital....................	42.39	A,B,C,E
ihlein Mercy Center.........................	46.56	A,B,D,E,F
lton County		
Gloversville Nursing Home..................	49.63	A,B,D
Wells Nursing Home.........................	39.22	A,B,E
Greene County		
Eden Park Nursing Home.....................	31.03	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Schedule of Rates

Region: NORTHEASTERN NEW YORK CON'T Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Montgomery County		
Mt. Loretto Convalescent&Rest Home	$27.77	B
Palatine Nursing Home	20.53	
Otsego County		
Oneonta Nursing Home	30.31	
Rensselaer County		
Eden Park Nursing Home	28.83	
Hallmark Nursing Home	32.29	B,D
Highgate Manor	38.11	B,C,D
Hoosick Falls Health Center	26.62	
Resurrection Rest	24.78	
Saratoga County		
Wesley Nursing Home	45.70	A,B,D,E
Schenectady County		
Hallmark Nursing Home	36.08	B,C,D
Kingsway Arms Nursing Center	37.11	
Silver Haven Nursing Home	33.87	
Schoharie County		
Eden Park Nursing Home	31.70	A,B,C
Warren County		
Adirondack Tri-County Nursing Home	38.57	B
Eden Park Nursing Home	35.38	B,C,E
Hallmark Nursing Center	31.53	
Washington County		
Fort Hudson Nursing Home	37.35	B,E
Indian River Nursing Home	27.75	B,D,E

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E-Physician Serv
F-Dental Services
G-All Inclusive

Schedule of Rates

Region: NORTHERN METROPOLITAN REGION Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Dutchess County		
Central Dutchess Nursing Home	$35.99	C
Eden Park Nursing Home	43.46	A, B, E
Ferncliff Nursing Home	45.75	G
Hyde Park Nursing Home	43.61	A, B, E, F
Lovely Hill Nursing Home	37.69	B
rtheastern Conference Nursing Home	40.59	B, D, F
nge County		
Nursing Home	26.44	
and Martin Nursing Home	23.79	E
tgomery Nursing Home	30.64	A, C
. Teresa's Nursing Home	41.71	B, C, D, E, F
lcox Nursing Home	40.31	B
Putnam County		
Kent Nursing Home	35.05	
Rockland County		
Elmwood Manor Nursing Home	51.16	A, B
Hillcrest Nursing Home	41.38	A, B
Maple Leaf Nursing Home	45.10	A, B
Nyack Manor Nursing Home	41.31	A, B
Ramapo Manor Nursing Home	40.16	A, B, C
Riverside Nursing Home	40.73	A, B
Tolstoy Foundation Nursing Home	45.63	A, B, D, E
llivan County		
Roscoe Community Nursing Home	40.76	B, C, D, F
Walnut Mountain Nursing Home	40.24	
Ulster County		
Hadler's Nursing Home	24.38	
Hudson Valley Nursing Home	32.60	B
Hutton Nursing Home	33.88	B, C,
New Paltz Nursing Home	34.25	

A- Prescription Drugs
Physical Therapy
-Occupational Therapy
-Speech Therapy
-Physician Services
-Dental Services

NURSING HOMES
Schedule of Rates

Region: NORTHERN METROPOLITAN REGION — Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Westchester County		
Asthmatic Children's Foundation	$29.63	E
Bayberry Nursing Home	31.76	
Bethel Nursing Home	50.90	
Brandywine Nursing Home	60.27	A
Briar Crest Nursing Home	30.97	
Cedar Manor Nursing Home	42.34	
Centre Manor Nursing Home	34.37	
Cortlandt Health Care Center	42.66	A
Dumont Nursing Home	44.24	
Home for Aged Blind	40.32✓	A,B,E,F
Howe Avenue Nursing Home	55.09	A,B,C,D
Hudson View Nursing Home	54.16	A
King Street Home, Inc	47.13	
Marrs Nursing Home	39.95	B,C
New Rochelle Nursing Home	43.84	B,F
Nursing Home & Extended Care Facility of White Plains	39.03	B,C,E
Port Chester Nursing Home	41.09	
St. Cabrini Nursing Home	57.29	A,B
Sans Souci Nursing Home	44.32	B
Sarah R. Newman Nursing Home	46.42	B,C,E
Shalom Nursing Home	48.95	A,B
Sky View Haven Nursing Home	49.08	B
Somers Manor Nursing Home	42.54	B
SprainBrook Manor Nursing Home	46.93	
Tarrytown Hall Nursing Home	43.58	A,B,C
Tibbits Health Care Facility	44.98	
United Home for Aged Hebrews	45.48	A,B,C,E,F
United Nursing Home for Aged, Inc	51.96	G
Wartburg Nursing Home	40.81	A,B,E,F
Waterview Hills Nursing Home	42.67	B,C,D
Westledge Nursing Home	46.48	B
White Plains Center for Nursing Care	38.96	B,C
Woodland Nursing Home	46.76	C

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES
Schedule of Rates

Region: LONG ISLAND

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Nassau County		
Bayview Nursing Home	$44.43	B
Belair Nursing Home	39.60	
Central Island Nursing Home	41.17	C
Daleview Nursing Home	44.63	B
East Rockaway Nursing Home	48.39	B
Five Towns Nursing Home	39.29	A,B,E
Franklin Park Nursing Home	42.99	B
Glengariff Nursing Home	43.20	B
Grace Plaza of Great Neck	42.17	
Long Beach Grandell	41.75	B
Long Beach Memorial Nursing Home, Inc	62.48	A,B,C
Long Island Tides Nursing Home	44.19	B
Mayfair Nursing Home	45.28	
Montclair Nursing Home	43.25	
Nassau Nursing Home	36.52	B
Park View Nursing Home	41.47	C
Rockville Nursing Center	41.72	B
Sands Point Nursing Home	37.21	C
South Shore Nursing Home	44.84	
Sun Harbor Manor Nursing Home	45.61	B
United Presbyterian Home at Syosset	42.98	A,B,C
Woodbury Nursing Home	44.11	
Ridgewood Nursing Home	42.97	
Suffolk County		
Berkshire Nursing Home	40.20	
Birchwood Nursing Home	50.55	B,C
Carillon House Nursing Home	42.24	
Cedar Lodge Nursing Home	34.38	
Consolation Nursing Home	52.42	A,B,C,D
Eastern Suffolk Nursing Home	37.38	
Hilaire Farm Nursing Home	40.22	
Little Flower Nursing Home and HRF	42.74	B
Oak Hollow Nursing Center	47.85	A,B,C
Patchogue Nursing Center	40.38	B,C
Port Jefferson Nursing Home	44.96	B
Riverhead Nursing Home	42.51	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES
Schedule of Rates

Period: 1/1/77-3/31/77

Region: LONG ISLAND

County Name of Facility	Daily Rate	Services Included in Rate
Suffolk County (con't)		
Ross Nursing Home..........................	$41.71	B
St. James Nursing Home........................	46.71	A,B,C,D
St. Johnland Nursing Home, Inc....................	50.60	G
Sayville Nursing Home..........................	46.55	B,C,D,F
Smithtown Nursing Home..........................	37.83	B,C,D
Sunrest Nursing Home..........................	38.57	B,E
Sunrise Manor Nursing Home....................	43.73	B,D
Todd Nursing Home..........................	44.26	B,C
Westhampton Nursing Home........................	34.30	
Woodhaven Manor Nursing Home and HRF..........	46.88	B
Non-occupation Services (Subchapter H) Long Beach Memorial Nursing Home, Inc. (Nassau County)	21.87	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES
Schedule of Rates

Region: NEW YORK CITY
Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Bronx County		
Astor Gardens Nursing Home	$37.68	B
Bainbridge Nursing Home	44.66	A,B
Beth Abraham Hospital	61.93	A,B,C,D,E
Bruckner Nursing Home	45.30	A,B,C,D
Concourse Nursing Home	54.24	G
Daughters of Jacob Nursing Home	68.14	G
Westchester Park Nursing Home	40.87	A,B,C
Fairfield Nursing Home	45.40	
Fieldston Lodge Nursing Home	45.73	B
Frances Schervier Home and Hospital	45.30	A,B,C,D,E
Hebrew Home for the Aged	63.17	A,B,C,E
Hebrew Hospital for Chronic Sick	65.82	G
House of Holy Comforter	44.40	A,B,C,E
Kings Harbor Care Center	53.22	A,B,C
Kings Harbor Manor Nursing Home	45.16	A,B,C,D
Kings Terrace Nursing Home	48.09	B
Kingsbridge Heights Nursing Home	51.73	A,B,C
Laconia Nursing Home	47.16	A,B,C
Methodist Church Home for the Aged	41.96	A,B,E
Morningside House Nursing Home	58.28	A,B,C,E,F
Morris Park Nursing Home	47.52	B,E
Mosholu Parkway Nursing Home	44.51	
Notre Dame Home for the Aged Poor	31.04	A,B,C
Palisade Nursing Home	75.02	A,B,C,E
Parkview Nursing Home	46.01	A,B,C
Pelham Parkway Nursing Home	46.29	A,B,C,D
Providence Rest Home for the Aged	46.10	A,B,C,E,F
Riverdale Nursing Home	45.46	B
Rofay Nursing Home	46.15	B
St. Patrick's Home for Aged and Infirmary	43.38	A,B,C,F
Split Rock Nursing Home	41.19	A,B
United Odd Fellows and Rebekah Home	41.75	A,B,E,F
University Nursing Home	38.21	B,C
W.K. Nursing Home	71.34	G
Wayne Health Related Facility	49.91	G
West Road Nursing Home	70.65	G
White Plains Nursing Home	41.51	A,B
Williamsbridge Manor Nursing Home	43.22	B,C
Workman's Circle Home and Infirmary	45.52	A,B,C,E,F
Non-occupant Services (Subchapter H)		
W.K. Nursing Home	20.88	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

NURSING HOMES

Schedule of Rates

Region: NEW YORK CITY

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Kings County		
Augustana Lutheran Home for Aged	$37.25	A,B,F
Baptist Home of Brooklyn	39.66	A,C,E,F
Belt Parkway Nursing Home	39.16	B
Brookdale Hospital Center Nursing Home	62.28	B,C,E
Brooklyn Methodist Church Home	46.54	G
Carlton Nursing Home	39.09	B
Caton Park Nursing Home	48.38	B
Cobble Hill Nursing Home	41.64	A,B,C
Concord Nursing Home	49.91	G
Crown Nursing Home	40.79	
Dover Nursing Home	37.95	
Farragut Nursing Home	36.86	B
Greenpark Care Center	53.16	B
Haym Salomon Home for the Aged	42.17	G
Holy Family Home 1601 8th Ave	34.54	A,B,C,E
Holy Family Home 1740 84th St	50.51	A,B,C,E
Ingersoll Nursing Home	40.17	
Lemberg Home and Geriatric Institute	42.01	A,B,C,E,F
Madonna Residence	39.70	A,B,C,E,F
Menorah Home and Hospital for Aged and Infirmary	54.80	A,B,C,D,E
M.J.G	71.05	G
New York Congregational Home	38.01	A,C,E,F
Norwegian Christian Home and Health Center	45.85	G
Oxford Nursing Home	37.54	B
Palm Gardens Nursing Home	49.51	B,C,D
Palm Tree Nursing Home	42.97	B,C,D
Prospect Park Nursing Home	39.61	
Rutland Nursing Home	88.35	G
Sea Crest Health Care Center	42.19	A,B
Sephardic Home for Aged	50.59	A,B,C,E,F
Sheepshead Nursing Home	49.58	A,B
Shore View Nursing Home	42.15	A,B
Wartburg Nursing Home	54.32	A,B,E,F
Willoughby Nursing Home	41.87	B
CABS Nursing Home Company	49.56	A, B,C,E

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

Schedule of Rates

Region: NEW YORK CITY Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
New York County		
Amsterdam House	51.99	G
American Nursing Home	$46.10	B,C
Bialystoker Home for the Aged	43.14	A,B,C,E
DeWitt Nursing Home	54.26	A,B,C
Florence Nightingale Nursing Home	52.64	A,B,D
Fort Tryon Nursing Home	47.95	A,B,C
Greater Harlem Nursing Home Co. Inc	54.64	G
Home of the Sages of Israel	39.56	A,B,E
Isabella Home Nursing Home	71.15	G
Jewish Home and Hospital for the Aged	64.55 -	A,B,C,E
Mary Manning Walsh Nursing Home	55.42	A,B,C,E,F
Mt. Carmel Home for the Aged	37.06	A,B,C,E
Park Crescent Nursing Home	43.14	B,C,D
Sangers Nursing Home	35.41	
Village Nursing Home	38.34	
Queens County		
Bayside Gardens Nursing Home	39.07	B
Bridgeview Nursing Home	42.33	B,C
Brookhaven Beach Nursing Home 17-11 Brrokhaven Ave.	46.77	A,B
Brookhaven Beach Health Related Facility 250 Beach 17th Street	38.82	A,B
Clearview Nursing Home	40.48	
Cliffside Nursing Home	46.15	B
College Nursing Home	46.17	B
Dry Harbor Nursing Home	43.46	A,B,C,D
Fairview Nursing Home	46.59	B
Far Rockaway Nursing Home	43.01	B
Flushing Manor Care Center	48.69	B,C,D
Flushing Manor Nursing Home	44.49	B,C
Forest Hills Nursing Home	43.02	B,C
Forest View Nursing Home	45.84	A,B,C
Franklin Nursing Home	50.37	A,B,C,D
Hillside Manor	51.47	B,C,D
Hollis Park Gardens Nursing Home	47.09	B
Holliswood Care Center	47.05	A,B,D
Jamacia Hospital Nursing Home	63.62	A,B,C,E
Jewish Insitute for Geriatric Care	73.23	G
Lawrence Nursing Home	52.16	B,C,E
Little Neck Nursing Home	49.09	

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

BEST COPY AVAILABLE

Nursing Homes

Schedule of Rates

Region: NEW YORK CITY CON'T

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Queens County (con't.)		
Long Island Nursing Home	$39.89	B,D
Lyden Nursing Home	47.32	B
Margaret Tietz Center for Nursing Care	53.20	G
Meadow Park Nursing Home	43.46	B
Midway Nursing Home	46.48	A,B,C,D
New Glen Oaks Nursing Home	47.58	
Oceanview Nursing Home	40.04	
Ozanam Hall of Queens Nursing Home	61.00	A,B,C,E,F
Park Nursing Home	44.53	B
Peninsula General Nursing Home	72.73	A,B,C,D,E
Promenade Nursing Home	42.50	B,D
Queen Of Peace Residence	41.17	A,B,C,E
Queens-Nassau Nursing Home	46.08	A,B,C
Rego Park Nursing Home	50.11	A,E
Resort Nursing Home	49.84	A,B,C
St. Mary's Hospital for Children	61.94	G
Surfside Nursing Home	42.52	B,D
Van Doren Nursing Home	46.17	B
Windsor Park Nursing Home	45.48	
Woodcrest Nursing Home	44.81	B
Woodhull Care Center	45.12	A,B,C
Rockaway Care Center	51.26	G
Richmond County		
Carmel Richmond Nursing Home	52.58	A,B,E,F
Clove Lakes Nursing Home	44.16	B,C
Eger Nursing Home	65.40	G
Golden Gate Health Care Center	43.79	A,B,C,D
Lily Pond Nursing Home	36.71	
New Brighton Manor Care Center	44.75	A,B,C
New Vanderbilt Nursing Home	44.62	B
Silver Lake Nursing Home	43.01	
Verrazano Nursing Home	40.50	B,C

A- Prescription Drugs
B- Physical Therapy
C- Occupational Therapy
D- Speech Therapy
E- Physician Services
F- Dental Services
G- All Inclusive

HEALTH RELATED FACILITIES

Schedule of Rates 478

Region: WESTERN NEW YORK

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Cattaraugus County		
Salamanca Nursing Home	$24.97	
Chautauqua County		
Gerry Nursing Home Company	24.11	A, B, D
Lutheran Retirement Home	21.36	
Presbyterian Homes of Western NY	24.75	
Erie County		
Aurora Park Nursing Home	23.40	B, C
Brothers of Mercy Nursing Home	27.41	A, B, C, D
Jennie B. Richmond Chaffee Nursing Home	31.41	B
Manhattan Manor Nursing Home	22.28	
Nazareth Health Related Facility	23.52	A, B
Niagara Frontier Methodist Home	14.32	B, C
Orchard Park Health Related Facility	22.95	C
Presbyterian Homes of Western NY	19.91	
Rosa Coplon Jewish Home and Infirmary	20.95	A, B, C, F
St. Francis Home of Williamsville	14.25	A
Seneca Manor Health Related Facility	23.03	
Tri-Del Nursing Center	28.88	B, C, D
24 Rhode Island Street Nursing Home	28.22	
Wheel Chair Home	20.96	
Williamsville View Manor	23.34	B, C, D, E
Niagara County		
Newfane Health Related Facility	22.74	A, B, C, D
Odd Fellows and Rebekah Nursing Home	27.70	
Niagara Geriatric Center	23.70	
Orleans County		
Orchard Manor Nursing Home and HRF	20.65	

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

Region: ROCHESTER REGION

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Monroe County		
Church Home of Protestant Episcopal Church	$13.97	B, C, E
Fairport Baptist Home	20.23	A, B, C, E, F
Goodman Gardens Nursing Home	24.91	
Hill Haven Health Related Facility	23.66	F
Jewish Home and Infirmary	23.15	A, B, C, D, F
Rochester Friendly Home	24.35	A, B, C, E, F
Rochester Methodist Home	13.65	
St. Ann's Nursing Home (The Heritage)	22.60	G
St. John's Home for the Aging	22.17	A, B, C, F
St. John's Nursing Home	32.31	G
Ontario County		
Geneva General Hospital Nursing Home	29.50	A, B, C, D, E
Thompson Nursing Home, Inc	25.15	A, B, C, E
Seneca County		
Seneca Nursing Home and HRF	24.79	B
Steuben County		
Hornell Nursing Home and HRF	24.37	

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
[illegible] All Inclusive

HEALTH RELATED FACILITIES

Schedule of Rates

Region: CENTRAL NEW YORK REGION

Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Broome County		
Elizabeth Church Manor Infirmary	$11.55	
Endicott Nursing Home	27.71	A, B
Good Shepherd-Fairview Home	17.42	A
Rivermede Manor Nursing Home	26.66	A, B
Susquehanna Nursing Home and HRF	22.54	B, C, D
Cayuga County		
Mercy Health & Rehabilitation Center	28.83	A,B,C,D
Chenango County		
Chase Memorial Nursing Home	23.72	B, C, D
Cortland County		
Highgate Manor of Cortland	22.81	B, C, F
Herkimer County		
Van Allen Nursing Home and HRF	27.97	B, C, F
Jefferson County		
Samaritan-Keep Nursing Home	28.00	A, B, C, D, F
Madison County		
Stonehedge-Chittenango Nursing Home & HRF	25.75	

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

on: CENTRAL NEW YORK REGION · Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Oneida County		
Betsy Ross Lodge HRF	$25.34	
Charles T. Sitrin Nursing Home	28.26	B, E
Eastern Star Home and Infirmary	23.47	A, B, C, E, F
Eden Park Nursing Home	21.24	B
Harding Nursing Home and HRF	23.84	B, C
HRF of Rome (Bethany House)	25.44	B
Martin Luther Nursing Home	25.71	B, C
Masonic Home and Health Facility	17.44	A, B, D, E
Onondaga County		
Loretto Geriatric Center	32.73	G
Syracuse Home Association	21.00	A
Oswego County		
Hillcrest Nursing Home	22.19	B, E
St. Luke's Nursing Home	25.11	A
St. Lawrence County		
Moongate Nursing Home and HRF	25.61	B
St. Regis Nursing Home	21.08	
United Helpers Nursing Home	22.83	B, C, D
Tompkins County		
Grand Lodge IOOF and Orphanage of NY	17.87	A
Lakeside Nursing Home	26.35	B, D, F

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES

Schedule of Rates

Region: NORTHEASTERN NEW YORK REGION Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Albany County		
Good Samaritan Nursing Home	$26.68	A
Teresian House Nursing Home	31.24	A, B, D
Our Lady of Hope Residence	22.61	B, F
Clinton County		
Meadowbrook Nursing Home	26.35	
Columbia County		
Adventist Nursing Home	26.81	A, B, D, E, F
Barnwell Nursing Home	22.58	A, B
Greene County		
Eden Park Nursing Home	26.40	
Rensselaer County		
Highgate Manor	26.70	B, C, D
Leisure Arms	19.71	
Resurrection Rest	19.65	
Rosewood Gardens HRF	28.14	
Saratoga County		
Wesley Nursing Home	34.41	A, B, D,E

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

483

ion: NORTHEASTERN NEW YORK REGION (con't.) Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Schenectady County		
Kings Way Arms Nursing Center	$24.40	
Schoharie County		
Eden Park Nursing Home	23.38	A, B, C
Warren County		
Eden Park Nursing Home	24.66	B, C, E
Washington County		
Indian River HRF	17.59	B, D, E
Fort Hudson Nursing Home	26.37	B, E

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

Region: NORTHERN METROPOLITAN REGION Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Dutchess County		
Eden Park Nursing Home	$28.96	A, B, E
Ferncliff Nursing Home	34.33	G
Fishkill Health Related Center	24.88	B
Lovely Hill Nursing Home	26.46	B
Orange County		
Sylcox Nursing Home	28.25	B
Rockland County		
Friedwald House	30.31	A, B
Ramapo Manor Health Related Facility	28.58	A, B, C
Sullivan County		
Walnut Mountain Health Related Facility	24.09	
Ulster County		
Hudson Valley Nursing Center	24.31	B

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES

485

Schedule of Rates

Region: NORTHERN METROPOLITAN REGION (con't.) Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Westchester County		
Bethel Methodist Home	$19.41	
Cortlandt Health Care Center	31.30	A
Home for the Aged Blind	26.26	A, B, E, F
King Street Health Related Facility	34.47	
Providence Rest	27.01	A, B, C, E, F
Sarah R. Neuman Nursing Home HRF	37.55	B, D
SkyView Haven Health Related Facility	33.03	B
Somers Manor Nursing Home and HRF	28.01	C
Swiss Home for the Aged	26.55	
Tarrytown Hall Health Related Facility	31.80	A, B, C
Tibbets Health Care Facility	30.98	
United Home for Aged Hebrews	22.50	A, B, C, E, F
Victoria Home for Aged British Men and Women	17.82	
Wartburg Intermediate Care Facility	24.22	A, B, E, F

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

HEALTH RELATED FACILITIES
Schedule of Rates

Region: LONG ISLAND REGION Period: 1/1/77-3/31/77

County Name of Facility	Daily Rate	Services Included in Rate
Nassau County		
Daleview Manor	$28.37	B
Five Towns Nursing Home HRF	23.88	A
Five Towns HRF - Cerebral Palsy Unit	40.42	A
Forest Manor	24.82	
Glengariff Nursing Home	29.49	B
Grace Plaza of Great Neck	27.37	
Long Beach Grandell	28.84	B
Long Beach Memorial Nursing Home	40.26	A, B, C
Rockville Residence Manor	31.30	
Sun Harbor Health Related Facility	31.58	B
United Presbyterian Home at Syosset	24.73	A, B, C
Woodbury East Health Related Facility	26.54	
Suffolk County		
Birchwood Nursing Home	36.35	
Carillon House Health Related Facility	34.64	
Consolation Nursing Home	33.61	A, B, C, D
Crest Hall Health Related Facility	30.68	A, B, C, F
Little Flower Nursing Home and HRF	33.19	B
Peconic Nursing and Adult Center	25.72	
Port Jefferson Nursing Home and HRF	31.64	B
Riverhead Nursing Home HRF	25.41	
St. James Plaza Health Related Facility	29.66	
St. Johnland Nursing Home	33.52	G
Smithtown Nursing Home	27.31	B, C, D
Sunrest Health Related Facility	32.04	
Woodhaven Manor Nursing Home and HRF	32.51	B

A - Prescription Drugs
B - Physical Therapy
C - Occupational Therapy
D - Speech Therapy
E - Physician Services
F - Dental Services
G - All Inclusive

EXHIBIT J

SKILLED NURSING FACILITIES

COUNTY	NAME OF INSTITUTION	No. of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Westchester	Home For Aged Blind	30	$55.34	$40.32	27.1	$157,890	$ 39,473
Queens	Margaret Tietz Center For Nursing Care	120	71.26	53.20	25.3	759,387	189,847
Kings	Holy Family	121	45.26	34.54	23.7	454,511	113,628
Bronx	Hebrew Home For The Aged	286	64.86	50.71	21.8	1,418,033	354,508
Bronx	United Odd Fellows Rebi-Kah Home	78	53.24	41.75	21.6	314,036	78,509
Kings	Haym Solomon Home For The Aged	126	53.41	42.17	21.0	496,250	124,063
Queens	St. Mary's Hospital For Children	78	77.43	61.94	20.0	423,360	105,840
Erie	Jennie B. Richmond Chaffee Nursing Home	40	46.35	37.53	19.0	123,621	30,905
Kings	Brookdale Hospital Center Nursing Home	220	76.75	62.28	18.6	1,115,463	278,866
Kings	Brooklyn Methodist Church Home	26	42.48	35.18	17.2	66,506	16,627
Westchester	Wartburg Nursing Home	80	49.21	40.81	17.1	235,469	58,867
Jefferson	Samaritan-Keep Nursing Home	196	45.55	38.24	16.0	502,039	125,510
Kings	Sephardic Home For Aged	129	60.18	50.59	15.9	433,483	108,371

COUNTY	NAME	No. of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Tioga	Tioga Nursing Home	80	$45.62	$38.68	15.2	$194,542	$ 48,636
Kings	New York Congregational Home	16	44.79	38.01	15.1	38,011	9,503
New York	Mary Manning Walsh Nursing Home	271	64.56	55.42	14.2	867,920	216,980
Cayuga	Mercy Health & Rehabilitation Center	252	44.46	38.23	14.0	550,114	137,529
Bronx	House of Holy Comforter	151	51.46	44.40	13.7	373,547	93,387
Kings	Concord Nursing Home	82	57.56	49.91	13.3	219,806	54,952
Kings	Lemberg Home & Geriatric Institute	29	48.54	42.48	12.5	61,579	15,395
Bronx	Palisade Nursing Home	256	73.49	64.27	12.5	859,363	214,841
Washington	Fort Hudson Nursing Home	80	34.81	30.51	12.4	120,538	30,135
Kings	Baptist Home of Brooklyn	20	45.23	39.66	12.3	39,035	9,759
Erie	Rhode Island Street Nursing Home Co.	44	42.73	37.73	11.7	77,088	19,272
Bronx	Workman's Circle Home and Infirmary	259	51.38	45.52	11.4	531,816	132,954
Tompkins	Reconstruction Home	72	35.21	31.20	11.4	101,168	25,292
Tompkins	Grand Lodge 100F Home & Orphanage	31	31.74	28.18	11.2	38,670	9,668

COUNTY	NAME OF INSTITUTION	No. of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Chautauqua	Lutheran Retirement	124	$39.24	$34.92	11.0	$187,702	$ 46,926
Monroe	St. Ann's Home For The Aged	354	42.60	38.08	10.6	560,668	140,167
Sullivan	Roscoe Community Nursing Home	85	45.25	40.76	9.9	133,730	33,433
Herkimer	Mohawk Valley Nursing Home	120	49.32	44.62	9.5	197,626	49,407
Oneida	Martin Luther Nursing Home	80	39.32	35.70	9.2	101,476	25,369
Erie	Rosa Coplon Jewish Home & Infirmary	111	48.80	44.40	9.0	171,136	42,784
Onondaga	Plaza Nursing Home	242	49.52	45.07	9.0	377,346	94,336
New York	Home Of The Sages of Israel	41	43.36	39.56	8.8	58,587	14,647
Westchester	United Nursing Home For Aged	120	56.97	51.96	8.8	210,660	52,665
Albany	Daughters of Sarah Nursing Home	200	50.92	46.43	8.8	314,659	78,665
Genesee	St. Luke's Manor	20	31.10	28.47	8.5	18,431	4,608
Westchester	St. Cabrini Nursing Home	200	62.51	57.29	8.4	365,818	91,455

COUNTY	NAME OF INSTITUTION	No. of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Suffolk	St. John Land Nursing Home	120	$54.91	$50.60	7.8	$ 181,227	$ 45,307
Columbia	Adventist Nursing Home	80	40.90	37.90	7.3	84,096	21,024
Richmond	Carmel Richmond Nursing Home	240	56.57	52.58	7.1	335,543	83,886
Rockland	Tolstoy Foundation Nursing Home	96	48.70	45.63	6.3	103,270	25,818
Bronx	Beth Abraham Hospital	504	66.00	61.93	6.2	718,769	179,693
Onondaga	St. Camillus Nursing Home	120	41.28	38.82	6.0	103,438	25,860
Bronx	Hebrew Hospital For Chronic Sick	196	49.60	46.63	6.0	203,975	50,994
Ontario	Geneva General Hospital Nursing Home	109	44.31	41.87	5.5	93,192	23,298
Onondaga	Loretto Geriatric Center	180	53.00	50.10	5.5	182,909	45,727
Queens	Jamaica Hospital Nursing Home	200	67.13	63.62	5.2	245,981	61,495
Westchester	United Home For Aged Hebrews	75	47.69	45.48	4.6	58,078	14,520
Kings	Wartburg Nursing Home	102	56.90	54.32	4.5	92,211	23,053

COUNTY	NAME OF INSTITUTION	No. Of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Erie	Wheel Chair Home	28	$28.87	$27.61	4.4	$ 12,362	$ 3,091
Ontario	Thompson Nursing Home	68	47.35	45.32	4.3	48,369	12,092
Oneida	Eastern Star Home & Infirmary	40	32.84	31.42	4.3	19,903	4,976
Westchester	Howe Avenue Nursing Home	150	57.51	55.09	4.2	127,195	31,799
Bronx	Methodist Church Home For The Aged	32	43.63	41.96	3.8	18,725	4,681
Oneida	Charles T. Sitrin Home	52	40.30	38.80	3.7	27,331	6,833
Erie	Brothers of Mercy Nursing Home	120	42.79	41.51	3.0	53,821	13,455
Monroe	Jewish Home and Infirmary	176	39.94	38.83	2.8	68,454	17,114
Oneida	Presbyterian Home Of Central New York	80	36.52	35.49	2.8	28,873	7,218
Kings	Norweigian Christian Home and Health Center	38	46.89	45.87	2.2	13,582	3,396
Chautauqua	Lakeshore Nursing Home	40	36.39	35.64	2.1	10,512	2,628
Bronx	Daughters of Jacob Nursing Home	300	69.30	68.14	1.7	121,939	30,485
Essex	Uihlein Mercy Center	96	47.31	46.56	1.6	25,229	6,307

COUNTY	NAME OF INSTITUTION	No. Of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Bronx	Morningside House Nursing Home	147	$59.04	$58.28	1.3	$ 39,147	$ 9,787
Westchester	Shalom Nursing Home	240	49.27	48.95	.6	26,911	6,728
Queens	Peninsula General Nursing Home	200	73.00	72.73	.4	18,922	4,731
Kings	M.J.G. Nursing Home	529	71.76	71.05	.1	131,607	32,902
Fulton	Wells Nursing Home	40	39.25	39.22	.1	421	105
Oneida	St. Joseph's Nursing Home Co. of Utica	120	40.96	40.58	.1	15,978	3,995

HEALTH RELATED FACILITIES

COUNTY	NAME OF INSTITUTION	No. Of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Richmond	Carmel Richmond N.H. Inc.	60	$38.74	$29.59	23.6	$192,370	$ 48,093
Monroe	St. Ann's N.H. (the Heritage)	237	28.43	22.60	20.5	484,151	121,038
Westchester	United Home For Aged Hebrews	109	27.61	22.50	18.5	195,169	48,792
Westchester	Wartburg Intermediate Care Facility	48	29.58	24.22	18.1	90,150	22,538
Westchester	Home of the Aged Blind	105	31.32	26.26	16.2	186,168	46,542
Kings	Sephardic Home For The Aged	132	40.69	35.00	14.0	263,178	65,795
Albany	Teresian House N.H.	300	36.28	31.24	13.9	529,805	132,451
Queens	Ozanam Hall of Queens N.H.	100	40.94	35.60	13.0	187,114	46,779
Queens	Bezalel N.H. Co.	120	35.05	31.03	11.5	169,033	42,258
Queens	Margaret Tietz Center	80	41.42	36.87	11.0	127,546	31,887
Bronx	Providence Rest Home For The Aged	60	30.19	27.01	10.5	66,856	16,714
Westchester	Providence Rest Home For The Aged	60	30.19	27.01	10.5	66,856	16,714

COUNTY	NAME OF INSTITUTION	No. Of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Kings	Menorah Home and Hospital	104	$28.29	$25.41	10.2	$104,952	$ 26,238
Jefferson	Samaritan-Keep N.H.	76	31.14	28 00	10.1	83,619	20,905
Chautauqua	Presbyterian Homes of Western New York	84	27.47	24.75	9.9	80,059	20,015
Kings	Lemberg Home & Geriatric Institute	25	28.45	25.65	9.8	24,528	6,131
Bronx	Daughters Of Jacob Nursing Home	210	45.61	41.28	9.5	318,619	79,655
Onondaga	Loretto Geriatric Center	400	36.00	32.73	9.1	458,323	114,581
Kings	Metropolitan Jewish Geriatric	357	27.83	25.36	8.9	308,979	77,245
Columbia	Adventist N.H.	40	28.91	26.81	7.3	29,434	7,359
Chinango	Chase Memorial N.H.	39	25.55	23.72	7.2	25,008	6,252
New York	Home For the Aged	45	28.18	26.17	7.1	31,694	7,924
Erie	Rhode Island Street Nursing Home	84	30.30	28.22	6.9	61,222	15,306
Niagara	New Health Related Facility	51	23.64	22.03	6.8	28,771	7,193

COUNTY	NAME OF INSTITUTION	No. Of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
New York	Mary Manning Walsh Home	76	$41.83	$39.05	6.6	$ 74,032	$ 18,508
Oswego	St. Luke's N.H.	120	26.82	25.11	6.4	71,902	17,976
Oneida	Martin Luther Nursing Home	80	27.31	25.71	5.9	44,851	11,213
New York	Jewish Home and Hospital For The Aged	38	33.19	31.60	4.8	21,171	5,293
Erie	Presbyterian Homes of Western New York	55	19.07	19.91	4.4	16,188	4,047
Bronx	Methodist Church Home	81	24.32	23.38	3.9	26,679	6,670
Erie	Brothers of Mercy Nursing Home	120	28.45	27.41	3.7	43,730	10,933
New York	Home of the Sages of Israel	14	26.32	25.38	3.6	4,612	1,153
Westchester	Bethel Methodist Home	112	20.10	19.41	3.4	27,079	6,770
Oneida	H.R.F. of Rome	100	26.32	25.44	3.3	30,835	7,709
Bronx	Hebrew Home For The Aged	298	31.39	30.47	2.9	96,066	24,017
Kings	Haym Solomon Home For The Aged	120	27.46	26.70	2.8	31,956	7,989

COUNTY	NAME OF INSTITUTION	No. Of Beds	Old Rate	1/1/77 Rate	Per Cent Of Loss	Dollar Loss 1977	Dollar Loss Jan. - March 1977
Oneida	Charles T. Sitrin Nursing Home	40	$28.99	$28.26	2.5	$ 10,232	$ 2,558
Kings	Concord Nursing Home	41	37.73	36.38	2.4	12,930	3,233
Bronx	St.Patrick's Home For The Aged	63	26.81	26.18	2.3	13,907	3,477
Bronx	Palisade Nursing Home Co.	82	41.40	40.80	1.4	17,240	4,310
Queens	Chapin Home For The Aged	65	32.80	33.23	1.3	9,794	2,449
Kings	Wartburg Lutheran Home	123	23.38	23.13	1.1	10,775	2,694
Albany	Good Samaritan Nursing Home	100	26.95	26.68	1.0	7,461	2,365
Dutchess	Ferncliff Nursing Home	80	34.41	34.33	.2	2,245	561

Served
Received
Entered in Docket
Entered in Diary For

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---------------------------------------x

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., et al.,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al.,

Defendants.

---------------------------------------x

76 Civ. 5113 (TPG)

AFFIDAVIT IN SUPPORT OF PRELIMINARY INJUNCTION

STATE OF NEW YORK)
: ss.:
COUNTY OF NEW YORK)

JEFFREY A. MISHKIN, being duly sworn, deposes and says:

1. I am an attorney associated with the firm of Proskauer Rose Goetz & Mendelsohn, attorneys for plaintiffs. I make this affidavit in support of plaintiffs' motion for a preliminary injunction.

2. At the oral argument on Friday, February 4, 1977, the Court expressed disappointment that plaintiffs' brief on the motion for a preliminary injunction did not include an analysis of the regulations promulgated by HEW on July 1, 1976 (45 C.F.R. §250.30(a)(3)(i)-(iv) in connection with the Medicaid Act requirement that, effective July 1, 1976, Medicaid reimbursement be made on a "reasonable cost-related basis." 42 U.S.C. §1396a(a)(13)(E). The Court indicated that it believed that such omission deprived it of material relevant to its consideration of the preliminary injunction motion.

3. As we attempted to explain at the oral argument, plaintiffs have asserted from the outset of this case that,

prior to the announcement of the challenged State regulations (Part 86-2) and rates, defendants determined that Medicaid reimbursement was to be limited to a certain dollar amount and only then proceeded to create regulations and rates which would ensure that such reimbursement did not exceed this predetermined ceiling. This process of working backwards to a predetermined fiscal result, without any consideration of the cost of operating nursing homes, was in utter disregard of the Medicaid Act requirement that reimbursement be on a "reasonable cost-related basis". The commentary to the July 1 regulations states explicitly that it is a violation of the statutory requirement of reasonable cost-related reimbursement for a State to limit reimbursement, as defendants have done here, solely on the basis of alleged financial constraints:

> ". . . a State would not satisfy the requirement of Section 1902(a)(13)(E) [42 U.S.C. §1396a(a)(13)(E)] if it paid, or gave assurance to pay, the amount determined under this section to the extent that State funds are available, or to the extent that State appropriations permit. To allow a State to limit its obligation under the statute by such a provision, as some comments suggested, would permit a State to defeat a major part of Congress' purpose in enacting [the section]."
>
> 41 F. Reg. 27302-27303, July 1, 1976

See also Memorandum in Support of Plaintiffs' Motion for a Preliminary Injunction, dated November 22, 1976, p. 12.

4. Because it is our factual contention that budgetary considerations alone formed the basis of the challenged regulations and rates, we deemed it unnecessary, at least at the preliminary injunction stage, to focus the

Court's attention on technical federal regulations specifying how a State might comply with the statutory requirements of reasonable cost-related reimbursement. This was particularly so since the detailed requirements for State Plans specified in the regulations are not scheduled to take effect until 1978. (45 C.F.R. §250.30(a)(3)(iv)). In any event, since a bald budgetary decision to limit Medicaid reimbursement, without regard to costs, is a plain violation of the statute, a factual finding for plaintiffs on that point would obviate the need for any consideration of the federal regulations.

5. Defendants might have chosen to place the federal regulations in issue by claiming that, notwithstanding the 1978 implementation date, those regulations were followed in arriving at the challenged State regulations and rates. However, defendants have yet to offer any affidavit or testimony explaining the factors that were taken into account in determining the challenged regulations and rates or denying that a "bottom line" amount for Medicaid reimbursement was fixed and that the challenged regulations and rates were created solely to ensure that such predetermined amount was not exceeded. Instead, defendants have chosen to contend only that each of the several hundred members of the class should bring an individual Article 78 proceeding and that the Eleventh Amendment bars the Court from granting any relief.

6. In our view, wholly apart from the other grounds specified in our papers, the failure of defendants for more than ten weeks even to attempt to explain how the regulations and rates were determined or to deny plaintiffs' claim that they resulted only from budgetary decisions raises serious

questions going to the merits of the issue whether the rates are on a reasonable cost-related basis and, given the undisputed hardship to nursing home residents should their Medicaid assistance be percipitously cut, plaintiffs are therefore entitled to a preliminary injunction. See Jacobson v. Armstrong, (No. 76-7336, 2d Cir. 1/25/77) (A copy of which is annexed hereto).

7. We very much regret that the Court regards our previous submissions as "superficial". We assure the Court that those papers represent a good faith effort on the part of counsel to present all matters which, in our judgment, are necessary for proper consideration for plaintiffs' motion for a preliminary injunction.

Jeffrey A Mishkin
Jeffrey A. Mishkin

Sworn to before me this
7th day of February 1977.

Notary Public

[illegible]
[illegible] Public, State [illegible]
[illegible]
Commission [illegible]

UNITED STATES COURT OF APPEALS

For the Second Circuit

No. 232—September Term, 1976.

(Argued October 18, 1976   Decided January 25, 1977.)

Docket No. 76-7[illegible]36

JACOBSON & COMPANY, INC.,

Plaintiff-Appellee,

v.

ARMSTRONG CORK COMPANY.

Defendant-Appellant.

Before:

HAYS, ANDERSON & GURFEIN,

Circuit Judges.

Appeal from an order of the United States District Court for the Southern District of New York, Edward Weinfeld, *Judge*, which granted plaintiff's motion for a preliminary injunction restraining defendant from terminating plaintiff as an authorized distributor of Armstrong products and from refusing to sell its products to plaintiff on non-discriminatory terms.

Affirmed.

SANFORD M. LITVACK, New York, N.Y. (James R. Withrow, Jr., John D. Gordan, III, Doris K. Shaw, Donovan Leisure Newton & Irvine, New York, N.Y., of counsel), *for Defendant-Appellant.*

David N. **Ellenhorn**, New York, N.Y. (Eugene I. Farber, Moses & Singer, New York, N.Y., of counsel), *for Plaintiff-Appellee.*

Hays, *Circuit Judge:*

Plaintiff-appellee Jacobson & Company, Inc. ("Jacobson") is a contractor in the business of furnishing and installing acoustical ceiling systems, interior partitions, and other interior building products. Defendant-appellant Armstrong Cork Company ("Armstrong") is the largest manufacturer of acoustical and non-acoustical ceiling products in the United States.

In March, 1963 Jacobson was designated an authorized distributor of Armstrong products in New York City, Long Island, Westchester and Rockland Counties (New York State), in Fairfield County, Connecticut, and in northern New Jersey. This relationship continued until March 19, 1976, when Armstrong notified Jacobson that its distributorship was terminated.

In a complaint filed May 26, 1976, Jacobson charged Armstrong with combining, conspiring, and attempting to monopolize and restrain trade, in violation of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2, section 3 of the Clayton Act, 15 U.S.C. § 14, and the Robinson-Patman Act, 15 U.S.C. § 13. Essentially, Jacobson alleged that Armstrong had allocated territories among its distributors and had engaged in certain vertical restraints. Jacobson claimed that Armstrong had terminated the distributorship in retaliation for Jacobson's refusal to adhere to these alleged unlawful practices.

Jacobson, arguing, *inter alia*, that it required access to Armstrong products in order to remain competitive as a ceiling contractor, sought a preliminary and permanent injunction restraining Armstrong from terminating plaintiff as an authorized distributor of Armstrong products and directing Armstrong to sell its products to plaintiff on nondiscriminatory terms. Jacobson also sought treble damages plus costs and attorneys fees.

On July 13, 1976, the United States District Court for the Southern District of New York, Weinfeld, *J.*, entered an order granting plaintiff's motion for a preliminary injunction, pending resolution of the merits of this controversy at trial. It is from this decision that defendant now appeals. We affirm the order of the district court.

I.

The district court recognized that the merits of this case turn entirely on factual determinations. Thus, the central issue presented is whether or not Armstrong terminated the distributorship because of Jacobson's resistance to Armstrong's alleged territorial allocations and resale restrictions. If this factual issue is resolved against Armstrong, then plaintiff will almost certainly be entitled to judgment, under the rule of *United States v. Arnold, Schwinn & Co.*, 388 U.S. 365, 379 (1967). If, however, the termination was for legitimate business purposes, then Armstrong will prevail.[1]

Judge Weinfeld, applying the familiar standard set forth in *Sonesta International Hotels Corp. v. Wellington Asso-*

---

[1] Armstrong contends that Jacobson was terminated because it made severe cutbacks in its sales organization and adopted a policy of bidding only on very large jobs, which are less profitable to Armstrong. Furthermore, Armstrong claims that as a result of other differences between the parties, their business relationship had deteriorated. Appellant's Brief at 5-8.

Of course, at this stage we express no opinion as to the merits of the substantive antitrust and factual issues involved in this case.

ciates, 483 F.2d 247 (2d Cir. 1973),[2] held that while plaintiff had not made a compelling case of probable success on the merits, it had shown sufficiently serious questions going to the merits to make them a fair ground for litigation. This, coupled with the court's finding that the potential hardship to Jacobson outweighed any inconvenience that Armstrong might suffer as a result of an injunction, led the court to conclude that plaintiff had satisfied the second alternative of the *Sonesta* test, and was thus entitled to a preliminary injunction.

Defendant now attacks this decision on two grounds. First, defendant argues that the district court misconstrued the standard to be applied in deciding preliminary injunction motions. Second, defendant claims that, in any event, the record does not support the district court's action. We reject both of these contentions

II.

Armstrong contends that a greater showing is required for the grant of a preliminary injunction which is mandatory rather than prohibitory in form, and that therefore the district court erred by failing to require a showing of "extreme or very serious damage." *Clune v. Publishers' Association of New York City*, 214 F.Supp. 520, 531 (S.D.

---

[2] We held in *Sonesto* that a preliminary injunction should issue on a showing of either

> "(1) probable success on the merits *and* possible irreparable injury, *or* (2) sufficiently serious questions going to the merits to make them a fair ground for litigation *and* a balance of hardships tipping decidedly toward the party requesting the preliminary relief."

483 F.2d at 250 (emphasis in original). *Accord: Triebwasser & Katz v. American Tel. & Tel. Co.*, 535 F.2d 1356 (2d Cir. 1976); *American Brands, Inc. v. Playgirl, Inc.*, 498 F.2d 947 (2d Cir. 1974); *Gulf & Western Industries, Inc. v. The Great Atlantic & Pacific Tea Co.*, 476 F.2d 687, 692-93 (2d Cir. 1973); *Checker Motors Corp. v. Chrysler Corp.*, 405 F.2d 319 (2d Cir.), *cert. denied*, 394 U.S. 999 (1969).

N.Y.), *aff'd on the opinion below*, 314 F.2d 343 (2d Cir. 1963).

We agree that a different standard applies to mandatory injunctions. Indeed, Judge Weinfeld recognized as much when he referred to "[t]he court's usual reluctance" to grant such relief. *Jacobson & Company, Inc.* v. *Armstrong Cork Company*, Civil No. 76-2376, at 15 (S.D.N.Y., filed July 2, 1976).

Nevertheless, issuance of a preliminary injunction, whatever its form, is in the district court's discretion and will not be overturned absent a showing of abuse or mistake. *Doran* v. *Salem Inn, Inc.*, 422 U.S. 922, 931-32 (1975); *Triebwasser & Katz* v. *American Tel. & Tel. Co., supra* at 1358; *S.C.M. Corp.* v. *Xerox Corp.*, 507 F.2d 358, 360 (2d Cir. 1974); 7 J. Moore, Federal Practice ¶65.04[2] at 65-47-49 (2d ed. 1975). We are not convinced that by failing to articulate the "extreme or very serious damage" formula of *Clune* the district court abused its discretion. Judge Weinfeld was aware that mandatory injunctions present a special case, but nonetheless held that plaintiff had made a sufficient showing to justify preliminary injunctive relief. We decline to disturb that decision.[3]

---

[3] This court has implicitly recognized that satisfaction of the *Clune* standard is not a *sine qua non* for obtaining a mandatory preliminary injunction. For example, in *Interphoto Corp.* v. *Minolta Corp.*, 417 F.2d 621 (2d Cir. 1969) and *Semmes Motors, Inc.* v. *Ford Motor Co.*, 429 F.2d 1197 (2d Cir. 1970), we upheld preliminary injunctions directing manufacturers to continue selling products to distributors, without requiring a showing of "extreme or very serious damage."

Appellant's argument, stripped to its essentials, is that the *Clune* standard *replaces* the *Sonesta* test in mandatory injunction cases. Both alternatives of *Sonesta*, however, require that the movant show a threat of irreparable harm. *See Triebwasser & Katz* v. *American Tel. & Tel. Co., supra*, at 1359 ("[The] language of the second prong of the *Sonesta* test does not eliminate the basic obligation . . . to make a clear showing of the threat of irreparable harm.") Since it seems to us that "irreparable harm" is indistinguishable from "extreme or very serious

Nor are we persuaded by Armstrong's argument that the district court misapplied the *Sonesta* test by granting the injunction without holding an evidentiary hearing. Defendant did not request an evidentiary hearing below and therefore "cannot be heard to complain" that a hearing was not conducted. *Semmes Motors, Inc.* v. *Ford Motor Co.*, 429 F.2d 1197, 1205 (2d Cir. 1970). As we said in the *Frank* case,

> "if a party is unwilling to have the issuance of a temporary injunction decided on affidavits, he must make his objection known; he may not gamble on the judge's accepting his affidavits rather than his adversary's and then seek a reversal if the result is disappointing."

388 F.2d at 493 n.6. *See also Dopp* v. *Franklin National Bank*, 461 F.2d 873, 879 (2d Cir. 1972).

Judge Weinfeld had before him not only the pleadings and affidavits of the parties, but also the transcripts of three depositions and a number of exhibits. Where the district court has the benefit of so complete a record, and the parties themselves fail to request a hearing, no evidentiary hearing is required.

Appellant also claims that in order to satisfy *either* prong of the *Sonesta* test, the movant must demonstrate a likelihood of success on the merits. Essentially, appellant argues that neither *Sonesta* nor any of the decisions from which the second branch of the *Sonesta* test is derived, *see Gulf & Western Industries, Inc.* v. *Great Atlantic & Pacific Tea Co.*, 476 F.2d 687, 692-93 (2d Cir. 1973); *Checker Motors Corp.* v. *Chrysler Corp.*, 405 F.2d 319, 323 (2d Cir.), *cert. denied*, 394 U.S. 999 (1969); *Dino De Lau-*

---

damage," we read *Clune* as merely a reaffirmation of the traditional reluctance to issue mandatory injunctions "in doubtful cases or where the injury complained of is capable of compensation in damages." *Clune* v. *Publishers' Association of New York City*, *supra* at 531.

rentiis Cinematografica, S.p.A. v. *D-150, Inc.*, 366 F.2d 373, 374-75 (2d Cir. 1966); *Unicon Management Corp.* v. *Koppers Company, Inc.*, 366 F.2d 199, 204-05 (2d Cir. 1966); *Hamilton Watch Co.* v. *Benrus Watch Co.*, 206 F.2d 738 (2d Cir. 1953), abandoned the "likelihood of success" requirement. We disagree.

In *Hamilton Watch Co.* v. *Benrus Watch Co.*, *supra*, Judge Frank declared that

> "[t]o justify a temporary injunction it is not necessary that the plaintiff's right to a final decision, after a trial, be absolutely certain, wholly without doubt; if the other elements are present (*i.e.*, the balance of hardships tips decidedly toward plaintiff), it will ordinarily be enough that the plaintiff has raised questions going to the merits so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberate investigation."

206 F.2d at 740 (footnote omitted).

We elaborated upon *Hamilton Watch* in *Unicorn Management Corp.* v. *Koppers Company, Inc.*, *supra* at 204-05, and *Dino De Laurentiis Cinematografica, S.p.A.* v. *D-150, Inc.*, *supra* at 375, where we held that a showing of probable success on the merits was required only where the movant has failed to show either a threat of irreparable harm or a balance of hardships in his favor. Accordingly, in *Checker Motors Corp.* v. *Chrysler Corp.*, *supra*, we affirmed the district court's denial of a preliminay injunction because "a review of the involved hardships and equities did not disclose a balance favoring injunctive relief. . . ." 405 F.2d at 323. *See also Gulf & Western Industries, Inc.* v. *Great Atlantic & Pacific Tea Co.*, *supra* at 692-93.

Against this background, it simply cannot be maintained that a temporary injunction will not be granted except on a showing of a likelihood of success. *Chicago, Rock Island & P.R. Co.* v. *Switchmen's Union of North America*, 292 F.2d 61 (2d Cir. 1961), *cert. denied*, 370 U.S. 936 (1962), and *Hoh* v. *Pepsico, Inc.*, 491 F.2d 556 (2d Cir. 1974), cited by appellant, are not to the contrary. In *Switchmen's Union* we reversed a preliminary injunction order not for want of a showing of probable success, but because we held clearly erroneous a finding of fact relied on by the district court in granting the injunction. 292 F.2d at 70-71. Furthermore, that case is inapposite insofar as our decision there was mandated by section 4 of the Norris-LaGuardia Act, 29 U.S.C. §104. *Id.* at 71.

In *Hoh*, we stated that "some likelihood of success" was required, 491 F.2d at 561, only *after* finding that the hardships did not tip decisively in the movants' favor, *id.* at 560. Clearly, *Hoh* was not a departure from *Hamilton Watch* and its progeny.[4]

We therefore reaffirm that the second branch of the *Sonesta* test requires no more than a showing of "sufficiently serious questions going to the merits to make them a fair ground for litigation." 483 F.2d at 250.

---

[4] Similarly, despite our statement in *Dopp* v. *Franklin National Bank*, *supra* at 878, that "a preliminary injunction . . . will not be granted unless the plaintiff can make a clear showing of probable success," we recognized that

> "if there is an imbalance of hardships and the equities weigh heavily in favor of the movant, an injunction will issue . . . if 'the plaintiff has raised questions going to the merits so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation and thus for more deliberate investigation.' *Hamilton Watch Co.* v. *Benrus Watch Co.*, 206 F.2d 738, 740 (2d Cir. 1953)."

Id. at 881. Accordingly, it was only in the light of Dopp's inability to prove irreparable injury that we reversed the district court's grant of a preliminary injunction. Since the showing of irreparable harm is required under *both* branches of the *Sonesta* test, *see* note 3 *supra*, *Dopp* does not support appellant's position.

III.

The only remaining question is whether the record supports the district court's findings that Jacobson raised substantial questions regarding the existence of antitrust violations and made a sufficient showing of irreparable injury. We hold that it does.[5]

A. *The Merits*

Jacobson cites three separate episodes in support of its charge that Armstrong terminated the distributorship because of Jacobson's refusal to adhere to unlawful trade restraints.

First, plaintiff claims that its attempts to penetrate the Philadelphia market in 1970-72 were stymied by Armstrong's refusal to quote prices or provide technical assistance from its local office. By requiring Jacobson to obtain pricing information and servicing from Armstrong's New Jersey office, plaintiff charges, defendant sought to protect the Berger Acoustical Company ("Berger"), its principal Philadelphia distributor. While Jacobson asserts no direct relationship between this episode and the 1976 termination, it does argue that these events illustrate Armstrong's desire to protect the alleged division of territories "and provide a backdrop against which to view later events." Civil No. 76-2376 at 5.

---

[5] We are aware that the standard for reviewing factual determinations where no evidence was taken in open court below is not whether the district court has abused its discretion. Rather, "this Court is able to exercise its discretion and review the papers *de novo.*" *San Filippo v. United Brotherhood of Carpenters and Joiners of America,* 525 F.2d 508, 511 (2d Cir. 1975). *See also Diversified Mortgage Investors v. U.S. Life Title Insurance Company of New York,* No. 75-7423 at 4545 (2d Cir., June 30, 1976); *Dopp v. Franklin National Bank, supra* at 873-79. Nevertheless, we agree with the district court that the affidavits and other evidence tendered by the parties justify the grant of a preliminary injunction.

In rebuttal, Armstrong contends that it was for purely administrative reasons that Jacobson was required to resort to the New Jersey office. This refusal to deal with Jacobson through offices located in other areas, appellant argues, does not rise to the level of an allocation of territories. *See GTE Sylvania, Inc. v. Continental T.V., Inc.*, 1976 Trade Cas. ¶ 60,848 (9th Cir. 1976); *World of Sleep, Inc. v. Stearns & Foster Co.*, 525 F.2d 40 (10th Cir. 1975).

Jacobson also contends that the termination was at least partly a reaction to the aggressive sales activities employed at its Elizabeth, New Jersey "supply center".[6] Jacobson supports this claim with evidence of (1) complaints by Berger to Armstrong about the supply center's discount offers and promotional mailings, and (2) an interoffice memo by Armstrong's general sales manager taking note of the supply center advertisements and expressing the view that Jacobson's activities would create problems for Armstrong with its other distributors.[7]

Armstrong replies that its concern was not with the sales themselves but with the disclosure in these advertisements of its confidential price list, and the tendency of the flyers to create the impression that Jacobson was receiving special price reductions from Armstrong.

Finally, Jacobson cites the circumstances surrounding its February, 1976 bid for a ceiling installation contract in Atlanta, Georgia. Armstrong agreed to provide Jacobson with pricing information and other technical data only after Jacobson objected that the refusal to render these services would be "anticompetitive." Armstrong had initially indicated its disapproval of Jacobson's bidding on Atlanta jobs, in light of Armstrong's "adequate coverage" there from local distributors. Jacobson won that contract, without bidding Armstrong products, and three weeks later was terminated as an Armstrong distributor.

---

[6] From its "supply center," Jacobson sells materials directly to purchasers who do their own installation. By buying on a non-installed basis, these purchasers are able to reduce costs.

[7] The memorandum, which consisted of hand-written notations annexed to a copy of a Jacobson Supply Center flyer, read as follows:

> "Here is an example of what I mean—we'll hear about this from many of our Philadelphia customers. These people don't give a damn about Armstrong. They never have and never will. I doubt very seriously if the $ we'll get in 76 is really worth the grief."

Armstrong claims that there was no antitrust significance to this termination, which it characterizes as a justifiable reaction to Jacobson's alleged practice of using Armstrong's price quotations to predict and undercut the bids of other Armstrong distributors.[8]

On this record, it is questionable whether Jacobson has shown that it is likely to succeed on the merits at trial. However, we think it plain that plaintiff has sustained its burden of raising serious questions going to the merits which make them a fair ground for litigation. The affidavits, depositions, and various exhibits raise at least the inference that Jacobson was terminated because of its extraterritorial sales activities. Although this issue cannot be finally decided until discovery is completed and the court has the benefit of a full factual presentation, Jacobson has satisfied the first half of the alternative *Sonesta* test.[9]

---

[8] In addition to the above contentions, Armstrong asserts that it had compelling business justifications for terminating Jacobson. *See* note 1 *supra*.

[9] Armstrong argues that even assuming anticompetitive motivations on its part, it was at most guilty of unilateral action, which fails to satisfy the "contract, combination . . . or conspiracy" requirement of Sherman Act section 1.

There was, however, sufficient evidence to show that the termination may have been part of an overall scheme to maintain a system of territorial allocations, which would be enough to bring Armstrong within the ambit of section 1. *See Albrecht v. Herald Co.*, 390 U.S. 145, 150 n.6 (1968); *Quinn v. Mobil Oil Co.*, 375 F.2d 273, 276 (1st Cir.), *petition for cert. dismissed*, 389 U.S. 801 (1967). Furthermore, there is at least

B. *The Balance of Hardships*

Judge Weinfeld found that loss of the Armstrong line would jeopardize Jacobson's good will and create a risk of "immeasurable harm" should Jacobson's customers and potential customers turn to competitors who do sell Armstrong products. Civil No. 76-2376 at 14. He also concluded that the competitive disadvantage at which Jacobson would be placed were it unable to bid Armstrong products was neither calculable nor compensable in dollars and cents. *Id.*

We agree that Jacobson presented ample evidence to show a threatened loss of good will and customers, both present and potential, neither of which could be rectified by monetary damages. Furthermore, it is clear that continuation of the injunction will cause Armstrong less harm than would be caused Jacobson were the injunction dissolved. Defendant concedes that it will suffer no financial loss as a result of continued dealings with plaintiff; indeed, the only injury claimed by Armstrong is that which arises from being compelled to sell to a distributor against its will. We find this to be insignificant, particularly in light of Armstrong's agreement, despite the termination notice, to sell Jacobson sufficient additional materials to fulfill obligations which existed at the termination date.

In sum, defendant has been unable to show that it will suffer any real harm if forced to continue selling to plaintiff pending the outcome of this action. Under these cir-

---

"fair ground for litigation over whether or not there was a combination or conspiracy between Armstrong and its distributors, since Jacobson's termination closely followed complaints to Armstrong by Berger and another distributor.

Of course, it is for the district court, after a full trial on the merits, to decide whether the Sherman Act covers Armstrong's actions. We merely hold that Jacobson has made a sufficient showing to justify preliminary injunctive relief.

cumstances, there has been a clear showing of "a balance of hardships tipping decidedly toward the party requesting the preliminary relief." *Sonesta International Hotels Corp. v. Wellington Associates, supra* at 250. *See generally Interphoto Corp. v. Minolta Corp.*, 417 F.2d 621 (2d Cir. 1969); *Bergen Drug Co. v. Parke, Davis & Co.*, 307 F.2d 725 (3d Cir. 1962).

Accordingly, the order of the district court is affirmed.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., ST. CABRINI NURSING HOME, INC., MARGARET TIETZ CENTER FOR NURSING CARE, INC., MOHAWK VALLEY NURSING HOME, INCORPORATED, DAUGHTERS OF SARAH NURSING HOME CO., INC., and LORETTO REST NURSING HOME CO., INC., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

76 Civ. 5113
(TPG)

NOTICE OF APPEAL

S I R:

PLEASE TAKE NOTICE that plaintiffs New York Association of Homes For Aging, Inc., Hospital Association of New York State, Inc., St. Cabrini Nursing Home, Inc., Margaret Tietz Center for Nursing Care, Inc., Mohawk Valley Nursing Home Incorporated, Daughters of Sarah Nursing Home Co., Inc., and Loretto Rest Nursing Home Co., Inc., on behalf of themselves and all other nonprofit residential health care facilities in the State of New York which render services to Medicaid-sponsored patients, hereby appeal to the United States Court of Appeals for the Second Circuit from the order of United States District Judge Thomas P. Griesa, announced on the record on February 9, 1976, a transcript of which was filed with the Clerk of the Court on February 17, 1977, denying plaintiffs' motion for a preliminary injunction to the extent it sought to enjoin defendants, pending final determination of this action, from applying or attempting to apply Part 88 or Part 86-2 of Title 10 of the New York Code of Rules and Regulations, or the Medicaid reimbursement rates promulgated thereunder, to the class of nonprofit residential health care facilities on whose behalf this action is brought for services rendered to Medicaid-sponsored patients on and after November 1, 1976, insofar as said Medicaid reimbursement rates effect reductions in the rates at which said facilities were being reimbursed as of October 31, 1976. A copy of the relevant portion of the February 9 transcript is annexed hereto.

Dated: New York, New York
February 23, 1977

PROSKAUER ROSE GOETZ & MENDELSOHN

By David J. Stern
Attorneys for Plaintiffs
300 Park Avenue
New York, New York 10022

TO:

LOUIS J. LEFKOWITZ, ESQ.
Attorney General of the
State of New York
Attorneys for Defendants
Two World Trade Center
New York, New York 10047

MR. MISHKIN: But, your Honor, the problems that we have in this class action transcend these individual cases, and I think that since November 19 we have seen a process that your Honor has suggested that we meet with the state. When we appear in court, there are new statements made by the defendants and new things are disclosed for the first time and we are sent back to discuss with them and see where we go from here. But at this point, your Honor, on behalf of the class that we represent, we are prepared to rest on the record as it is now.

THE COURT: Then I will tell you right here and now that I will deny the motion for preliminary injunction on a class basis. I do so on the basis of the record that demonstrates to me that when the facts are gone into as to the individual homes, there is a wide and substantial discrepancy as to the issues as to each individual home. This has been true of every single situation which I have inquired about and which has been presented to me.

MR. MISHKIN: Your Honor --

THE COURT: If you will let me finish, I will make my findings and conclusions, because I am finally resolved on this and I can so state right now.

The record amply demonstrates that there are differences in the rates granted to the homes. There are differences in the rates granted to the homes. There are differences with respect to the procedures engaged in by the Department of Health and the Department of the Budget with respect to these homes. There are differences, substantial differences, in the financial condition of the different homes. There are substantial differences in the effect of the various rates. The transcript of today's

(continued on next page)

hearing will demonstrate that beautifully. I would not add one word in my judgment to the transcript of today's hearing to support my findings in this regard.

I think when we are dealing with requests for relief which would involve the payment of millions of dollars of additional money to the members of the plaintiff class over what rates may be in effect, this is something which this Court must view seriously, it must view carefully, and it cannot, in my view, be dealt with on a mass basis no matter how much work is involved. If it becomes too burdensome to be handled by this Court, at least by me as an individual judge, there will be a way found to handle it. But the solution is not to indulge in some broadbrush treatment, which I would regard as simply sloppiness. And I won't do it that way.

If the process becomes too burdensome, there are magistrates and indeed there might be a procedure for the appointment of a master. That is a way it can be handled.

But the thing that will not be done, unless higher authority directs it to be done, is to deal with this on a mass basis.

For those reasons I am denying the preliminary injunction as to the class.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC.,
HOSPITAL ASSOCIATION OF NEW YORK STATE, INC.,
ST. CABRINI NURSING HOME, INC., MARGARET
TIETZ CENTER FOR NURSING CARE, INC., MOHAWK
VALLEY NURSING HOME, INCORPORATED, DAUGHTERS
OF SARAH NURSING HOME CO., INC., and LORETTO
REST NURSING HOME CO., INC., on behalf of
themselves and all other nonprofit residential
health care facilities which render services
to Medicaid-sponsored patients,

Plaintiffs,

- against -

AFFIDAVIT

76 CIV 5113 TPG

PHILIP L. TOIA, as Commissioner of Social
Services of the State of New York, ROBERT
P. WHALEN, as Commissioner of Health of the
State of New York, PETER GOLDMARK, as
Director of the Budget of the State of New
York, and HUGH L. CAREY, as Governor of the
State of New York,

Defendants.

STATE OF NEW YORK)
COUNTY OF ALBANY)$^{:ss}$

JONATHAN M. BRANDES, being duly sworn, deposes and says:

1. I am an attorney duly admitted to practice in the State of New York and a member of the staff of the Litigation Bureau in the Office of Counsel, New York State Department of Social Services.

2. I am familiar with the facts and circumstances in the above-captioned matter.

3. On December 30, 1976 I personally delivered a package to the United States Post Office in Albany, New York which was addressed to the Region II office of the Department of Health, Education and Welfare (DHEW) in New York City.

4. Upon information and belief, the said package contained a submission to DHEW, number 76-51, which was designed to comply with Social and Rehabilitation Service Action Transmittal 76-116 which required the submission of an Amendment to the New York State Title XIX Plan describing the methods and standards used by the State for determining reasonable cost-related payments to residential health care facilities.

5. A copy of said submission 76-51 is attached hereto and made a part hereof.

Jonathan M. Brandes
JONATHAN M. BRANDES

Sworn to before me this
24 day of February, 1977

Glenn R. Lefebvre
Notary Public

GLENN R. LEFEBVRE
NOTARY PUBLIC, State of New York
Reg. No. [illegible]
Qualified in Albany County
Commission Expires March 30, 19 77

76-51 folder

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES
1450 WESTERN AVENUE
ALBANY, N.Y. 12243

PHILIP L. TOIA
COMMISSIONER

12/30/76

Dear Mr. Toby:

As required by SRS-AT-76-116(MSA), we are submitting herewith under Submittal 76-51 seven (7) copies of pages 20, 21, and Attachment 4.19-D of the New York State Title XIX Plan.

Attachment 4.19-D replaces the material previously submitted as Attachment 4.19-A, Sections 88.1 through 88.28.

May we look forward to your early formal approval?

Sincerely,

Philip Toia
Philip L. Toia

Mr. William Toby
Acting Regional Commissioner
Region II
Social and Rehabilitation Service
Department of Health, Education
and Welfare
26 Federal Plaza
New York, New York 10007

☆ U.S. GOVERNMENT PRINTING OFFICE – 1974-665-818

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Washington, D. C. 20201

Submit 6 Copies

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL SOCIAL AND REHABILITATION SERVICE STATE PLAN PROGRAMS

TO: REGIONAL COMMISSIONER
SOCIAL AND REHABILITATION SERVICE
DEPARTMENT OF HEALTH, EDUCATION, & WELFARE
REGION II

TRANSMITTAL NUMBER: 76-51

STATE: New York

PROGRAM IDENTIFICATION: XIX

TYPE OF PLAN MATERIAL (CHECK ONE)

☐ NEW STATE PLAN
☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
☒ AMENDMENT

PROPOSED EFFECTIVE DATE: January 1, 1976

COMPLETE NEXT 4 BLOCKS IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

FEDERAL REGULATION CITATION
45 CFR 250.30

NUMBER OF THE PLAN SECTION OR ATTACHMENT
Pages 20 and 21
Attachment 4.19-D

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Pages 20 and 21
Section 86.34 of Attachment 4.19-A

SUBJECT OF AMENDMENT
Methods and Standards for Establishing Payment Rates – Residential Health Care Facilities

GOVERNOR'S REVIEW (CHECK ONE)

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

SIGNATURE OF STATE AGENCY OFFICIAL

TYPED NAME: Philip L. Toia

TITLE: Commissioner

DATE: 12/30/76

RETURN TO: NYS Department of Social Services
Tenyck Office Building
40 North Pearl Street
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

DATE RECEIVED

DATE APPROVED

PLAN APPROVED – ONE COPY ATTACHED

EFFECTIVE DATE OF APPROVED MATERIAL

SIGNATURE OF REGIONAL OFFICIAL

TYPED NAME:

TITLE:

REMARKS

BEST COPY AVAILABLE

[illegible] 76 51

Revision: SRS-AT-76-116(MSA)
July 23, 1976

State NEW YORK

Citation
45 CFR
250.30
P.R. 40-4
(C-4, C-7)
AT-75-72
AT-75-116
AT-76-107

4.19 Payments for Medical and Remedial Care and Services

(a) All requirements of 45 CFR 250.30 are met.

(b) ATTACHMENT 4.19-A describes the methods and standards used, after review and approval, for the payment of the reasonable cost of inpatient hospital services.

(c) ATTACHMENT 4.19-D describes the methods and standards used by the State for determining payments to be made on a reasonable cost-related basis to skilled nursing and intermediate care facilities for services provided under the plan. The description include requirements for cost finding and cost reporting, auditing procedures, items of allowable cost, and methods and standards for determining reasonable cost-related payment rates.

The State agency assures that the amount determined under the approved principles and provisions described in ATTACHMENT 4.19-D will be paid to skilled nursing and intermediate care facilities for services under the State plan.

☐ Section 4.19(c) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

(d) ATTACHMENT 4.19-B describes the policy and methods used in establishing payment rates for each of the other types of care or service listed in Section 1905(a) of the Act that is included in the program under the plan.

F-F76 51

State NEW YORK

(e) Payment is made for reserving beds in long-term care facilities for recipients during their temporary absence for the purposes(s) indicated below.

☒ Yes:

  ☒ for periods of hospitalization for acute conditions, up to 15 days per hospitalization

  ☒ for leaves of absence up to 18 days per year

  ☐ within the limits of a State-approved therapeutic or rehabilitative program described in ATTACHMENT 4.19-C.

☐ Not applicable. The State does not make payments for such bed reservations.

Citation
45 CFR
249.32
P.R. 40-8
(C-1)

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

(a) No direct payments are made for physicians' or dentists' services to individuals (1) who are receiving assistance under the State's title IV-A plan, or (2) with respect to whom supplemental security benefits are being paid under title XVI of the Act, or (3) who are receiving or eligible for a State supplementary payment or would be eligible therefor if not in a medical institution and who are eligible for medical assistance to the same extent as individuals described in (1) and (2).

(b) Direct payments are made to individual recipients other than those described in paragraph (a).

☐ Yes, for ☐ physicians' services
☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to individual recipients.

Attachment 4.19-D

276 51

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State New York

Methods and Standards for Establishing Payment Rates-

Residential Health Care Facilities

(Statutory authority: Public Health Law, Sections 2803 and 2808)

STATE NEW YORK

Attachment 4.19-D

[illegible] 76 51

SUBPART 86-2

RESIDENTIAL HEALTH CARE FACILITIES

(Statutory authority: Public Health Law, § 2808)

Sec.
86-2.1 Definition
86-2.2 Financial and statistical data required
86-2.3 Uniform system of accounting and reporting
86-2.4 Generally accepted accounting principles
86-2.5 Accountant's certification
86-2.6 Certification by operator or officer
86-2.7 Audits
86-2.8 Patient days
86-2.9 Effective period of reimbursement rates
86-2.10 Computation of basic rate
86-2.11 Ceilings on allowable costs for reimbursement purposes
86-2.12 Adjustments to basic computed rate
86-2.13 Final rates
86-2.14 Revisions in certified rates
86-2.15 Rates for residental health care facilities without adequate cost experience
86-2.16 Less expensive alternatives
86-2.17 Allowable costs
86-2.18 Recoveries of expense
86-2.19 Depreciation
86-2.20 Interest
86-2.21 Capital cost reimbursement for proprietary residential health care facilities (effective January 1 1976)
86-2.22 Moveable equipment
86-2.23 Research
86-2.24 Educational activitie
86-2.25 Compensation of operators and relatives of operat
86-2.26 Costs of related organizations
86-2.27 Termination of servic
86-2.28 Return on investment
86-2.29 Effective date

Section 86-2.1 Definition. As used in this Subpart, the term "residential health care facility" shall be deemed to include all facilities or organizations covered by the term "nursing home or health related facility" as defined in Article 28 of the Public Health Law, provided that such facility possesses a valid operating certificate issued by the State Commissioner of Health and where

required, has been established by the Public Health Council.

I 86-2.2 Financial and statistical data required. (a) Each
residential health care facility shall complete and file with the
New York State Department of Health and/or its agent, annual financial
and statistical report forms supplied by the department and/or its
T agent. Residential health care facilities certified for title XVIII
of the federal Social Security Act of the federal Social Security
/ (medicare) shall use the same fiscal year for title XIX/(medicaid)
as is used for title XVIII. All residential health care facilities
A must report their operations from January 1, 1977 forward on a
calendar year basis.

(b) Financial and statistical reports required by this/ Sub Part
shall be submitted to the department and/or its agent no later than
L 120 days following the close of the fiscal period. Extensions of
time for filing reports may be granted upon application received
at least 15 days prior to the due date of the report and only in
I those circumstances where the residential health care facility
established, by documentary evidence, that the report cannot be
C filed by the due date for reasons beyond the control of the facility.

(c) In the event a residential health care facility fails to
file the required financial and statistical report on or before the
due dates, or as the same may be extended pursuant to subdivision (b
S of this section, the State Commissioner of Health shall reduce the
current rate by two percent for a period beginning on the first day

of the calendar month following the due date of the required report and continuing until the last day of the calendar month in which said required report is filed.

(d) In the event that any information or data which a residential health care facility has submitted to the State Department of Health on required reports, budgets or appeals for rate revisions intended for use in establishing rates is inaccurate or incorrect, whether by reason of subsequent events or otherwise, such facility shall forthwith submit to the Department a correction of such information or data which meets the same certification requirements as the document being corrected.

(c) A cost report shall be filed in accordance with this section by each new facility for the first six month period during which the facility has had an over-all average utilization of at least 90 percent of bed capacity. This report shall be filed and properly certified within 60 days following the end of the six month period covered by the report.

86-2.3 Uniform system of accounting and reporting. Residential health care facilities shall maintain their records in accordance with the appropriate uniform chart of accounts and definitions established by the State Commissioner of Health. Records shall be maintained by residential health care facilities in accordance with the appropriate section of Subchapter A of Chapter V of this Title, Medical Facilities, Minimum Standards. Rate schedules shall not be certified by the Commissioner of Health unless

residential health care facilities are in full compliance with all reporting requirements.

86-2.4 Generally accepted accounting principles. The complation of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the residential health care facility unless the reporting instructions authorize specific variation in such principles.

86-2.5 Accountant's certification. The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant in accordance with such regulations as the State Commissioner of Health shall establish. The requirements of this Section shall not apply to residential health care facilities operated by units of government of the State of New York.

86-2.6 Certification by operator or officer. The financial and statistical reports shall be certified by the operator or an officer of the medical facility.

86-2.7 Audits. (a) All fiscal and statistical records and reports shall be subject to audit.

(b) Subsequent to the filing of required fiscal and statistical reports, field audits shall be conducted of the records of residential health care facilities, in a manner to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (medicare-medicaid and other organizations and agencies having audit responsibilities) to

satisfy the department's auditing needs.

(c) The required fiscal and statistical reports shall be
I subject to audit for a period of six years from the date of their
filing with the department. This limitation shall not apply to
situations in which fraud may be involved.

(d) Residential health care facilities shall be given 30 days
T after the mailing of notification of audit findings to appeal such
findings, by submitting data intended to justify the facility's
position in the areas of disagreement. Failure by the residential
health care facility to reply to such findings within the 30 day
A period, or to receive from the department an extension of time for
reply shall be considered as acceptance of the findings.

(e) Rate revisions resulting from audit findings may be made
retroactively to the period or periods during which the rates based
L on the periods audited were established.

(f) All overpayments resulting from rate revisions shall bear
interest at the rate of seven percent per annum from the date of
I such overpayments and be subject to such penalties as the Commissioner
of Health may impose for the incorrect completion of the report or
the failure to file required revisions of the report in the amount of
C up to 25 percent of the overpayment for negligent incorrect completion
or negligent failure to file revisions and up to 100 percent of the
S overpayment for willful incorrect completion or willful failure to
file revisions.

86-2.8 Patient days. (a) A "patient day" is the unit of measure denoting lodging provided and services rendered to one patient between the census-taking hour on two successive days.

(b) In computing patient days, the day of admission shall be counted but not the day of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes residential health care facility days shall be determined by using the higher of the minimum utilization factor of 90 percent of certified beds or the actual patient days of care as furnished by the facility.

86-2.9 Effective period of reimbursement rates. Certification of reimbursement rates of payment by governmental agencies pursuant to this Subpart shall be for the rate period beginning January 1, 1976 and ending March 31, 1977.

86-2.10 Computation of basic rate. Basic rates shall be computed on the basis of allowable fiscal and statistical data submitted by the residential health care facility for the fiscal year ended at least six months prior to the effective date of the rate. The computed rates shall be all-inclusive rates taking into consideration total allowable costs and total inpatient days. In those cases where patients paid for by government agencies are not assigned accommodations on the basis of medical necessity, availability of beds of all types, or where a facility has a practice resulting in services to governmental patients being provided at lower than average cost, appropriate modifications in allowable costs shall be made.

I T A L I C S

86-2.11 Ceilings on allowable costs for reimbursement purposes.

(a) For the purpose of establishing allowable cost ceilings for determining reimbursement rates effective January 1, 1976 for governmental payments, skilled nursing facilities and health related facilities will be grouped separately with respect to size as indicat in paragraph (1) of this subdivision and with respect to the service ratings received for those functions indicated in subparagraphs (i) through (v) in paragraph (2) of this subdivision and by size only with respect to (vi) in (2) below:

(1) Size of facilities,

- (i) 50 beds and under;
- (ii) 51 to 99 beds;
- (iii) 100 to 199 beds;
- (iv) 200 to 299 beds;
- (v) over 300 beds.

(2) Functions,

- (i) Nursing;
- (ii) Food-nutrition;
- (iii) Leisure time activities;
- (iv) Cleanliness and safety;
- (v) Social work;
- (vi) Administration.

(b) Allowable costs for reimbursement for any function for which a facility receives a "Good - State" rating may not exceed the 60th percentile of the per diem range of costs as reported for the base year by all facilities receiving a "Good - State" service rating for that rated function within the size groups as indicated paragraph (1) of subdivision (a) of this section.

(c) Allowable costs for reimbursement for any rated function for which a facility receives a "Good - Federal" service rating

ITALICS

may not exceed the 35th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(d) Allowable costs for reimbursement for any rated function for which a facility receives a "Needs Improvement" rating may not exceed the 25th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(e) Allowable costs for reimbursement for any rated function for which a facility receives an "Unacceptable" rating may not exceed the 10th percentile of the per diem range of costs for facilities receiving "Good - State" service ratings for the appropriate size group.

(f) Ceilings shallnot be imposed on costs for any rated function for which a facility receives a "Very Good" service rating.

(g) Allowable per diem costs for administration may not exceed the 50th percentile of the range of per diem costs reported for the base year for all facilities within the size groups indicated in Paragraph 1 of Subdivision A of this section.

(h) In establishing the ranges of per diem costs, by function, facilities will be grouped without regard to sponsor or geographic area. An economic leveling factor developed on the basis of area salaries will be used to make the costs comparable.

(i) Any amount to be eliminated in accordance with this section in determining reimbursement rates will be equal to the excess of the total per diem costs computed from the total costs reported in the base year for the functions in/ paragraph (2) of Subdivision A of this sec over the total of the functional ceilings established for the service ratings and administration of the facility.

86-2.12 Adjustments to basic computed rate.

(a) To the allowable basic rate, computed in accordance with ceiling limitations, and prior to the addition of capital costs, realty leases, return on net equity capital, and leases, depreciation and interest related to equipment there will be added a factor to project allowable cost increases during the effective period of the reimbursement rate. Such factor shall be determined as follows:

(1) The elements of a residential health care facility's cost shall be weighted based on a sampling of data by the following categories:

(i) Salaries and employee health and welfare expense to be computed based on a total of sub-weights.
(ii) Nonpayroll administrative and general expense.
(iii) Nonpayroll household and maintenance expense.
(iv) Nonpayroll dietary expense.
(v) Nonpayroll professional care expense.

(2) Each weight shall be adjusted by the appropriate price index for each category noted above, as well as for subcategories. Included among these cost indicators are elements of the United

I T A L I C S

I
T
A
L
I
C
S

States Department of Labor consumer and wholesale price indices and special indices developed by the State Commissioner of Health for this purpose.

(3) Geographic differentials may be established where appropriate.

(b) During the rate period, the cost indicators used in determining the projection factors in establishing the current certified rates may be compared with available data on such indicators, and any other economic indicators as deemed appropriate by the Commissioner of Health, as of mid-point in the rate period. Based upon such review the Commissioner may, in his discretion either certify new rates or adjust subsequent rates for any period or portion thereof when he determines that such new rates or adjusted rates are necessary to avoid substantial inequities arising from the use of previously certified rates.

86-2.13 Final rates. Rate adjustments may be made to correct errors in the determination of rates.

Errors resulting from submission of information by a residential health care facility may be corrected if brought to the attention of the State Commissioner of Health within 60 days of receipt of the commissioner's rate computation sheet. Errors resulti from the rate computation process may be corrected if brought to the

ITALICS

attention of the commissioner within four months of receipt of the commissioner's rate computation sheet.

86-2.14 Revisions in certified rates. (a) The State Commissioner of Health may consider only those applications for prospective revisions of certified rates which are based on

(1) requests for revisions in 1975 reimbursement rates for cost increases incurred prior to the effective date of this section;

(2) errors made in the rate computation process or in the submission by a residential health care facility which have been brought to the attention of the Commissioner within the time limits prescribed in Section 86-2.13 of this title;

(3) significant increases in the over-all operating costs of a residential health care facility resulting from the implementation of additional programs, staff or services specifically mandated for the facility by the Commissioner;

(4) significant increases in the over-all operating costs of a residential health care facility resulting from capital renovation, expansion, replacement or the inclusion of new programs, staff or services approved for the facility by the Commissioner;

(5) requests for waivers of any provisions of this Subpart for which waivers may be granted by the Commissioner as prescribed in specific sections; and

(6) changes in the method of providing services which result in a lower over-all cost for the services provided;

(7) requests for relief from the ceiling provisions of this

I T A L I C S

part. For such relief, a residential health care facility must demonstrate that its range of approved services, patient mix, lengths of appropriate stays or other pertinent factors are direct causes for all or part of the costs in excess of the ceilings. Such relief shall not result in a rate which exceeds that based on maximum reimbursable State standards, unless a waiver of such standards is granted by the Commissioner. If relief is granted, the resulting revised rates shall become effective as of the first day of the rate period.

(b) Any request for the prospective modification of a certified rate must be accompanied by financial, statistical and program evidence sufficient to demonstrate over-all fiscal impact.

(c) Any modified rate certified thereunder shall be effective on the first day of the month following 30 days after receipt of the request and justification.

(d) The State Commissioner of Health may in his discretion, certify a new rate, direct that a hearing be conducted to recommend whether a new rate should be certified, or disapprove the request for certification. In any event, the Commissioner shall notify the requesting party of his determination.

(e) In reviewing appeals for revisions to certified rates the Commissioner may refuse to accept or consider an appeal from a residential health care facility:

(1) providing an unacceptable level of care as determined after review by the State Hospital Review and Planning Council;

(2) operated by the same management when it is determined by the department that this management is providing an unacceptable level of care as determined after review by the State Hospital and Planning Council in one of its facilities;

(3) where it has been determined by the Commissioner that the operation is being conducted by a person or persons not properly established in accordance with the Public Health Law;

(4) where a fine or penalty has been imposed on the facility and such fine or penalty has not been paid.

In such instances the provisions of subdivision (c) of this section shall not be effective until the date the appeal is accepted by the Commissioner.

(f) Any residential health care facility determined after review by the State Hospital Review and Planning Council to be providing an unacceptable level of care shall have its current reimbursement rate reduced by 10 percent as of the first day of the month following 30 days after the date of the determination. This rate reduction shall remain in effect for a one-month period or until the first day of the month following 30 days after a determination that the level of care has been improved to an acceptable level, whichever is longer. Such reductions shall be in addition to any revision of rates based on audit exceptions.

(g) Any residential health care facility eligible for title XVIII of the federal Social Security Act (medicare) certification providing services to patients insured under title XVIII of the federal Social Security Act which is not, or ceases to be, a title XVIII provider of

care shall have its current reimbursement rate reduced by 10 percent. This rate reduction shall remain in effect until the first day of the month following certification of such a provider by the title XVIII program. Such rate reductions shall be in addition to any revision of rates based on audit exceptions.

86-2.15 Rates for residential health care facilities without adequate cost experience. Rates certified for facilities where adequate fiscal and service data are not provided shall be determined on the basis of generally applicable factors, including but not limited to the following:

(a) The usual and customary rates, for comparable services, in the geographic area.

(b) Satisfactory cost projections.

(c) Allowable actual expenditures.

(d) An anticipated utilization of no less than the average for the geographic area or the minimums established in this Subpart, whichever is greater.

86-2.16 Less expensive alternatives. Reimbursement for the cost of providing services shall be the lesser of the actual costs incurred or those costs which could reasonably be anticipated if such services had been provided by the operation of joint central services or use of facilities or services which could have served effective alternativ or substitutes for the whole or any part of such service.

86-2.17 Allowable costs. (a) To be considered as allowable in determining reimbursement rates, costs shallbe properly chargeable

I to necessary patient care. Except as otherwise provided in this Subpart, or in accordance with specific determination by the Commissioner, allowable costs shall be determined by the application of the principles of reimbursement developed for determining payments under

T the title XVIII/ of the Federal Social Security Act (medicare) program.

(b) Allowable cost shall include a monetary value assigned to

A services provided by religious orders and for services rendered by an owner and operator of a residential health care facility.

(c) Allowable costs may not include amounts in excess of reasonable or maximum title XVIII/ of the Federal Social Security Act (medicare) costs or in excess of

L customary charges to the general public. This provision shall not apply to services furnished by public providers free of charge or at a nominal fee.

(d) Allowable costs shall not include expenses or portions of

I expenses reported by individual residential health care facilities which are determined by the Commissioner not to be reasonably related

C to the efficient production of service because of either the nature or amount of the particular item.

(e) Any general ceilings applied by the Commissioner, as to

S allowable costs in the computation of reimbursement rates, shall be published in a hospital memorandum or other appropriate manner.

(f) Allowable costs shall not include costs not properly relat

to patient care or treatment which principally afford diversion,
entertainment or amusement to owners, operators or employees of
I residential health care facilities.

(g) Allowable costs shall not include any interest charged
related to rate determination or penalty imposed by governmental
agencies or courts, and the costs of policies obtained solely to
T insure against the imposition of such a penalty.

(h) Allowable costs shall not include the direct or indirect
costs of advertising, public relations or promotion except in those
instances where the advertising is specifically related to the
A operation of the residential health care facility and not for the
purpose of attracting patients.

(i) Effective for fiscal years ending in 1976 and thereafter
allowable costs per unit of service in a base year shall not include
L any cost increases over the allowable costs in the prior year which
are in excess of the inflation factor used by the New York State Department of Health in
determining the reimbursement rate in effect during such base year,
I unless the cost increases in the base year resulted in a rate
revision related to such year in accordance with section 86-2.14 of thi
subpart .

(j) Allowable costs shall not include costs of contributions
C or other payments to political parties, candidates or organizations.

(k) Allowable costs shall include only that portion of the
dues paid to any professional association which has been demonstrated,
S to the satisfaction of the Commissioner, to be allocable to expenditures
other than for public relations, advertising, or political

contributions. Any such costs shall also be subject to any cost ceilings that may be promulgated by the Commissioner.

86-2.18 Recoveries of expense. (a) Operating costs shall be reduced by the cost of services and activities which are not properly chargeable to patient care. In the event that the State Commissioner of Health determines that it is not practical to establish the costs of such services and activities, the income derived therefrom may be substituted for costs. Examples of activities and services covered by this provision include:

(1) drugs and supplies sold for use outside the residential health care facility;

(2) telephone and telegraph services for which a charge is made;

(3) discount on purchases;

(4) living quarters rented to employees;

(5) employee cafeterias;

(6) meals provided to special nurses or patients' guests;

(7) operation of parking facilities for community convenience;

(8) lease of office and other space of concessionaires providing services not related to residential health care facility service;

(9) tuition and other payments for education service, room and board and other services not directly related to residential health care facility service.

86-2.19 Depreciation. (a) Reported depreciation based on approved historical cost of buildings, fixed equipment and improvements thereto is recognized as a proper element of cost for voluntary and public residential health care facilities.

(b) In the computation of rates effective for voluntary residential health care facilities, depreciation shall be included on a straight line method on plant and non-moveable equipment. Depreciation shall be funded unless the Commissioner of Health shall have determined, upon application by the residential health care facility, and after inviting written comments from interested parties, that the requested waiver of the requirements for funding is a matter of public interest and necessity. In instances where funding is required, such fund may be used only for capital expenditures with approval as required or for the amortization of capital indebtedness.

(c) In the computation of rates for public residential health care facilities, depreciation is to be included on a straight line method on plant and non-moveable equipment.

(d) Residential health care facilities financed by mortgage loans pursuant to the Nursing Home Companies Law or the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan

I T A L I C S

financed portion of the facilities the State Commissioner of Health
shall allow level debt service on the mortgage loan, together with
I such required fixed charges, sinking funds and reserves as may be
determined by the Commissioner as necessary to assure repayment of
the mortgage indebtedness.

T 86-2.20 Interest. (a) Necessary interest on both current and
capital indebtedness is an allowable cost for voluntary and public
residential health care facilities. For proprietary residential
health care facilities, necessary interest is allowable except for
A those amounts related to land, building, fixed equipment and improve-
ments thereto.

(b) To be considered as an allowable cost, interest shall be
incurred to satisfy a financial need, and at a rate not in excess
L of what a prudent borrower would have had to pay in the money market
at the time the loan was made. Also, the interest shall be paid to
a lender not related through control, ownership, affiliation or
personal relationship to the borrower, except in instances where the
I prior approval of the Commissioner of Health has been obtained.

(c) Interest expense shall be reduced by investment income with
C the exception of income from funded depreciation, qualified pension
funds, or in instances where income from gifts or grants is restricted
by donors. Interest on funds borrowed from a donor restricted fund
S or funded depreciation is an allowable expense.

(d) Interest on capital debt in excess of 50 percent of the net depreciated value of buildings and fixed equipment for voluntary residential health care facilities shall not be considered an allowable cost, unless the State Commissioner of Health, as of July 1, 1971, has already finally approved the fiscal feasibility of a project, or thereafter shall have determined, after inviting written comments from interested parties that capital debt in excess of such amount is a matter of public interest and does not threaten the continued existence of the institution.

86-2.21 Capital cost reimbursement for proprietary residential health care facilities (effective January 1, 1976). (a) As used in this section the following terms shall have their respective meanings:

(1) Allowed facility cost. The term "allowed facility cost" shall mean the aggregate of the building portion and land portion determined by the Commissioner pursuant to this section.

(2) Approved book value. The term "approved book value" shall mean the total certified historical cost, net of accumulated depreciation or amortization thereof, of all assets constituting plant, non-moveable equipment and land actually used to provide necessary patient care to the extent said cost is approved by the Commissioner as reasonable, necessary and in the public interes

(3) Approved project cost. The term "approved project cost" shall mean the aggregate of costs actually incurred by the facility for the acquisition of land and the acquisition or constructi

I T A L I C S

of plant and non-moveable equipment used to provide necessary patient care to the extent said costs are approved by the Commissioner as reasonable, necessary and in the public interest.

(4) Capital cost. The term "capital cost" shall mean the approved cost for land, building, fixed equipment and improvements thereto.

(5) Commissioner. The term "Commissioner" shall mean the State Commissioner of Health.

(6) Department. The term "Department" shall mean the State Department of Health.

(7) Facility. The term "facility" shall include every "residential health care facility" as that term is defined in Article 28 of the Public Health Law or in regulations of the Department, organized and operated on a for-profit basis.

(8) Improvement. The term "improvement" shall mean any addition to, replacement of or improvement of a capital item of plant or non-moveable equipment approved by the Commissioner as reasonable, necessary and in the public interest.

(9) Improvement cost. The term "improvement cost" shall mean the actual expenditure or portion thereof attributable to an improvement approved by the Commissioner as reasonable, necessary and in the public interest.

(10) Improvement period. The term "improvement period" shall mean the period of years represented by the greater of

76 51

(i) the remaining useful facility life as of the initial improvement year; or

I (ii) the useful improvement life.

(11) Initial facility year. The term "initial facility
year" shall mean the calendar year in which a facility commenced
T operations as determined by the Commissioner.

(12) Initial improvement year. The term "initial
improvement year" shall mean the calendar year in which an improvement
is first used by a facility in the provision of necessary
A patient care as determined by the Commissioner.

(13) Rate of return. The term "rate of return" shall
mean the annual rate of return on net equity capital invested and
used in the provision of patient care, as said rate is determined
L by the United States Department of Health, Education and Welfare
as an element of reasonable-cost for purposes of payments to or
reimbursement of proprietary providers under Title XVIII of the
federal Social Security Act.

I (14) Useful facility life. The term "useful facility
life" shall mean a period of 40 years measured from the intial
facility year.

C (b) Subject to subdivision (c) of this section, the reimbursement
rate of every proprietary residential health care facility certified
by the Commissioner pursuant to Article 28 of the Public Health Law
shall include a capital cost component determined in accordance with
S subdivision (d) or subdivision (e) of this section.

ITALICS

(c) The provisions of subdivision (b) of this section shall not apply to any facility which, as of the effective date of this section or therafter, is within the provisions of subdivision (g) or subdivision (h) of this section.

(d) (1) Except as provided by subdivision (c) of this section and subject to the provisions of paragraph (1) and paragraph (4) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the useful facility life, a payment factor representing an amount sufficient to pay, over the useful facility life, the Building Portion of allowed facility cost together with an annual rate of return thereon, as determined by the Commissioner in the initial facility year, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed Building Portion; and

(ii) for each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement together with an annual rate of return thereon, as determined by

the Commissioner in the initial improvement year, in equal constant annual payments as if each of such rate of return on the then unreimbursed amount of improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the then unreimbursed amount of improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient to pay an annual rate of return, determined by the Commissioner in the initial facility year, on the Land Portion of allowed facility cost.

(2) The payment factors provided by paragraph (1) of this subdivision shall be adjusted prospectively by the Commissioner at 10 year intervals measured from the initial facility year or initial improvement year. Each such adjustment shall be made by the Commission determining the average of the rates of return in each of the five years preceding the adjustment and utilizing such average rate of return to recompute.

(i) the payment factor to be applied pursuant to paragraph (1)(i) of this subdivision to the then

ITALICS

remaining unreimbursed Building Portion of allowed facility cost over the then remaining useful facility life; and

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this subdivision to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this subdivision.

(3) For purposes of this section the Building Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to construction or acquisition of plant and nonmoveable equipment, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(4) For purposes of this section the Land Portion of allowed facility cost shall consist of that portion of the approved project costs of a facility attributed by the Commissioner to the acquisition of land, as may be adjusted by the Commissioner pursuant to paragraph (5) of this subdivision.

(5) The Commissioner may, in his discretion, determine maximum per bed approved project costs related to the efficient production of services by a facility. For purposes of this section the

ITALICS

facility cost of any facility shall not exceed an amount equal to the applicable maximum per bed approved project cost times the number of beds specified in the operating certificate issued to the facility by the Commissioner pursuant to Article 28 of the Public Health Law. The Commissioner shall reduce the Building Portion or Land Portion of any facility whose approved project cost exceeds the maximum determined in accordance with this subsection by the amount which the Commissioner finds attributable to such portion.

(e) (1) Except as provided in Subdivision (c) of this section and subject to the provisions of paragraphs (3), (4), (7), (8) and (9) of this subdivision, the capital cost component for any facility whose construction is completed and whose initial facility year occurred prior to the calendar year in which this section becomes effective shall consist of the sum of the following three payment factors:

(i) for each year of the then remaining useful facility life, a payment factor representing an amount sufficient to pay, over the remaining useful facility life, the remaining unreimbursed Building Portion of allowed facility cost, together with an annual rate of return thereon determined pursuant to paragraph (2) of this subdivision, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed amount of the Building Portion and the remainder of each such annual payment were to be applied in reduction of the Building Portion; and

(ii) For each year of the improvement period, a payment factor representing an amount sufficient to pay, over the improvement period, the improvement cost of any improvement, together with an annual rate of return thereon determined pursuant to paragraph (2) of this subdivision, in equal constant annual payments, as if each of such annual payments were to be applied first to payment of such rate of return on the then unreimbursed improvement cost of such improvement and the remainder of each such annual payment were to be applied in reduction of the improvement cost of such improvement; and

(iii) for each year or portion thereof that the facility holds a valid operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law, a payment factor representing an amount sufficient either

to pay an annual rate of return determined pursuant to paragraph (2) of this subdivision on the Land Portion of allowed facility cost or to reimburse the facility for the total payments or approved portion thereof made by the facility for the

I
T
A
L
I
C
S

use of land rented pursuant to a lease which meets the specifications of subparagraphs (i), (ii) and (iii) of subdivision (h) (1) of this section.

(2) The rate of return used to determine the payment factors pursuant to paragraph (1) of this subdivision shall

(i) for facilities whose initial facility year was at least five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the five years preceding the year in which this subpart becomes effective or

(ii) for facilities whose initial facility year was less than five years prior to the year in which this subpart becomes effective, be the average of the rates of return in each of the years in which the facility was established by the Public Health Council and operated pursuant to an operating certificate issued by the Commissioner pursuant to Article 28 of the Public Health Law.

(3) The payment factors provided by paragraph (1) of this subdivision shall be adjusted prospectively by the Commissioner at 10 y intervals measured from the year in which this subpart becomes effectiv Each such adjustment shall be made by the Commissioner determining the average of the rates of return in each of the five years preceding the

adjustment and utilizing such average rate of return to recompute

(i) the payment factor to be applied pursuant to paragraph (1) (ii) of this subdivision to the then remaining unreimbursed Building Portion of allowed facility cost over the remaining useful facility life and

I

T

A

L

I

C

S

T. #76 51

I
T
A
L
I
C
S

(ii) the payment factor to be applied pursuant to paragraph (1) (ii) of this subdivision to the then remaining unreimbursed improvement cost of any improvements; and

(iii) the payment factor based on the Land Portion of allowed facility cost pursuant to paragraph (1) (iii) of this subdivision.

(4) Notwithstanding the provisions of paragraph (1) of this subdivision, the capital cost component for facilities whose initial facility year was more than 20 years prior to the year in which this subpart becomes effective and which are found by the Commissioner to comply in all respects with the provisions of the State Hospital Code shall;

(i) for the remaining useful facility life be not less than an amount equal to $200 multiplied by the number of beds specified in the operating certificate issued to such facility by the Commissioner pursuant to Article 28 of the Public Health Law; and

(ii) for each year beyond the remaining useful facility life consist of the payment factor

I T A L I C S

applicable to such facility pursuant to paragraph (1) (iii) of this subdivision.

(5) Except as provided in subparagraph (i) of this paragraph for purposes of this section the Building Portion of allowed facility co shall consist of the portion of the approved book value of a facility attributed by the Commissioner to plant and non-moveable equipment, as adjusted by the Commissioner pursuant to paragraph (7) and paragraph (8) of this subdivision.

(6) Except as provided in paragraph (9) of this subdivision, for purposes of this section the Land Portion of allowed facility cost shall consist of the portion of the approved book value of a facility attributed by the Commissioner to land, as adjusted pursuant to paragraph (7) and paragraph (8) of this subdivision.

(7) The Commissioner shall reduce the approved book value of any facility so as to disregard prior transactions involving the facility which he finds were not bona fide or the terms of which are found to be other than fair and reasonable.

(8) The Commissioner may, in his discretion, reduce the approved book value of the facility to take into account such factors as the age, size, location and condition of the facility.

(9) In lieu of determing allowed facility cost pursuant to paragraph (5) and Paragraph (6) of this subdivision, the Commissioner shall, based on approved project cost or approved book values of facilities of comparable age, size, location and condition, assign

ITALICS

an allowed facility cost, and allocate the same between the Building Portion and Land Portion thereof, to

(i) every leased facility which operates under a lease which the Commissioner finds to be other than bona fide or the terms of which are found to be other than fair and reasonable; and

(ii) every facility for which records on asset book values are not available or not verifiable to the satisfaction of the Commissioner; and

(iii) every facility which, after the effective date of this subpart, ceases to be eligible for reimbursement pursuant to subdivision (h) of this section; and

(iv) every facility whose construction was completed prior to the calendar year in which this subpart becomes effective and whose initial facility year occurs in or after the calendar year in which this subpart becomes effective.

provided that this section shall not apply to any such facility which is able to provide the Commissioner with information which the Commission finds sufficient to determine its approved book value.

(f) Subject to the provisions of subdivision (g) of this section, the capital cost component of any facility that is sold, transferred or the subject of any other transaction after March 10, 1975 shall be determined in accordance with the provisions of this section as if such sale, transfer or other transaction had not occurred.

(g) (1) Notwithstanding the provisions of subdivision (b) and subdivision (f) of this section, the capital cost component of any facility shall, upon the sale or transfer of such facility to a voluntary sponsor or the conversion of such facility to a voluntary facility, be determined pursuant to sections 86-2.19 and 86-2.20 of this Subpart and paragraph (2) of this subdivision.

(2) The approved book value of a facility within paragraph (1) of this subdivision, determined for purposes of sections 86-2.19 and 86-2. of this Subpart shall be determined in accordance with the provisions of this section as though such sale, transferor conversion had not occurred.

(h) (1) The provisions of subdivision of this section shall not apply to any facility which, as of the effective date of this subpart, is located in and operated from leased space pursuant to a lease

(i) which was entered into and approved for reimbursement prior to March 10, 1975; and

(ii) which the Commissioner finds to be bona fide, valid and non-cancellable; and

(iii) the terms of which the Commissioner finds to be fair and reasonable; and

I T A L I C S

(iv) the payments or portion thereof made pursuant to which are found by the Commissioner to be the proper basis for reimbursement of capital cost paid to such facility pursuant to article 28 of the Public Health Law prior to March 10, 1975.

(2) The capital cost component of any facility within the provisions of paragraph (1) of this/subdivision shall consist of a payment factor sufficient to reimburse the facility for the total payments required under the lease thereof to the extent approved by the Commissioner pursuant to paragraph (1) of this subdivision.

86-2.22 Moveable Equipment. Necessary and reasonable expenses related to moveable equipment (depreciation computed on a straight lin method or accelerated under a double declining balance on sum-of-the years digits method, interest on indebtedness, lease etc.) are considered allowable costs for residential health care facilities subject to such ceilings as may be established and promulgated by the Commissioner of Health.

86-2.23 Research. (a) All research costs shall be excluded from allowable costs in computing reimbursement rates.

(b) Research includes those studies and projects which have as their purpose the enlargement of general knowledge and understanding; are experimental in nature and hold no prospect of immediate benefit to the hospital or its patients.

I T A L I C S

86-2.24 Educational activities. The costs of educational activities less tuition and supporting grants shall be included in the calculation of the basic rate provided such activities are directly related to patient care services.

86-2.25 Compensation of operators and relatives of operators.

(a) Reasonable compensation for operators or relatives of operators for services actually performed and required to be performed shall be considered as an allowable cost. The amount to be allowed shall be equal to the amount normally required to be paid for the same service provided by a non-related employee, as determined by the State Commissioner of Health. Compensation shall not be included in the rate computation for any services which the operator or relative of the operator is not authorized to perform under New York State law and regulation.

(b) Any amount reported as compensation for services rendered by an operator or relative of an operator shall not be allowed in excess of the maximum allowance for full time services in carrying out his primary function.

(c) For purposes of subdivision (a) of this section, in determining a reasonable level of compensation for operators or relatives of operators the commissioner may consider the quality of care provided to patients by the facility during the year in question

86-2.26 Costs of related organizations. (a) Costs applicable to services, facilities and supplies furnished to a residential health

care facility by organizations related to the provider by common ownership or control are includable in the computation of the basic rate at the cost to the related organization.

(b) If the provider has any interest whatsoever in the related organization, the final payment rate shall include both the costs of the related organization in providing the services, facilities and supplies (and a return on the equity capital of the related organization).

86-2.27 Termination of service. The Department of Health shall be notified immediately of the deletion of any previously offered service or of the withholding of services from patients paid for by government agencies. Such notification shall include a statement indicating the date of the deletion or withholding of such service and the cost impact on the residential health care facility of such action. Any overpaymen by reason of such deletion of previously offered service shall bear interest and be subject to penalties both in the manner provided in section 86-2.7 of this Sub/part.

86-2.28 Return on investment. In computing the allowable costs of a proprietary residential health care facility, there will be included a reasonable return on net equity capital, excluding capital invested in land, plant, fixed equipment and improvements thereto, invested for necessary and proper operation for patient care activities. The percentage to be used in computing this allowance will be a rate determined annually by the commissioner as reasonably related to the then current money market.

86-2.29 Effective date. This subpart shall take effect immediately and shall

[illegible]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

NEW YORK ASSOCIATION OF HOMES FOR AGING, INC., et al.,

Plaintiffs

- against -

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, et al.

Defendants

76 Civ. 5113
(TPG)

STATE OF NEW YORK)
COUNTY OF ALBANY) ss.

CARMINE D. ASPARRO, being duly sworn, deposes and says:

1. I am Assistant Commissioner for Health Care Financing Operations in the Department of Health of the State of New York.

2. The Commissioner of Health certified certain rate revisions to the Director of the Budget, pursuant to Part 86-2 of 10 NYCRR, who approved the rates as evidenced by the following copies of the official records of the Department of Health annexed hereto:

Re: LORETTO GERIATRIC CENTER

Letter dated February 10, 1977 (Exh. A) and letter dated February 18, 1977 (Exh. B), with schedules of rate revisions certified by the Commissioner of Health and approved by the Director of the Budget.

Re: MARY MANNING WALSH NURSING HOME COMPANY, INC.

Letter dated February 17, 1977 (Exh. C) with schedule of rate revisions certified by the Commissioner of Health and approved by the Director of the Budget.

Carmine D. Asparro
Carmine D. Asparro

Sworn to before me this
9th day of March, 1977

Notary Public

DONALD A. MacHARG
Notary Public, State of New York
[illegible] in Albany County
[illegible]

to: Hon. George Mantzoros, Asst. Attorney G.
Dept. of Law
2 World Trade Center
New York, NY
from: Estelle Wall-Bur. Reimbursement Rate
(2 pages)

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

ROBERT P. WHALEN, M.D.
COMMISSIONER

February 10, 1977

Dear Mr. Goldmark:

In accordance with the provisions of Section 2807 of the Public Health Law, I am certifying to you that the attached proposed rate schedule for payments for medical services at the Loretto Geriatric Center, Health Related Facility, Onondaga County, for the period November 1, 1976 through March 31, 1977 are reasonably related to the cost of efficient production of such services.

The formula on which these rates are based was promulgated as Part 86 of the Commissioner's Administrative Rules and Regulations.

Sincerely yours,

Robert P. Whalen, M.D.
Commissioner of Health

The rates established are hereby approved.

Paul J. Elston
For Peter C. Goldmark, Jr.
Director of the Budget

Attachment

Honorable Peter C. Goldmark, Jr.
Director of the Budget
State Capitol
Albany, New York

Ex. A

LORETTO GERIATRIC CENTER

Health Related Facility - November 1, 1976 through December 31, 1976

	From	To
Daily	$31.54	$35.72
Monthly	$959.00	$1,086.00
January 1, 1977 through March 31, 1977		
Daily	$32.73	$37.42

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

ROBERT P. WHALEN, M.D.
COMMISSIONER

EDWARD D. COATES, M.D.
FIRST DEPUTY COMMISSIONER

February 18, 1977

Dear Mr. Goldmark:

In accordance with the provisions of Section 2807 of the Public Health Law, I am certifying to you that the attached proposed rate schedule for payments for medical services at the LORETTO GERIATRIC CENTER, Skilled Nursing Facility, Onondaga County, for the period November 1, 1976 through March 31, 1977 are reasonably related to the cost of efficient production of such services.

The formula on which these rates are based was promulgated as Part 86 of the Commissioner's Administrative Rules and Regulations.

Sincerely yours,

Edward D. Coates

Edward D. Coates, M.D.
First Deputy Commissioner

The rates established are hereby approved.

For Paul J. Elston

Peter C. Goldmark, Jr.
Director of the Budget

Attachment

Honorable Peter C. Goldmark, Jr.
Director of the Budget
State Capitol
Albany, New York

Ex. B

STATE OF NEW YORK • DEPARTMENT OF HEALTH
TOWER BUILDING • EMPIRE STATE PLAZA • ALBANY, N.Y. 12237

DIVISION OF HEALTH CARE FINANCING
WILLIAM F. McCANN
ASSISTANT COMMISSIONER

ROBERT P. WHALEN, M.D.
COMMISSIONER

February 18, 1977

Honorable Peter C. Goldmark, Jr.
Director of the Budget
State Capitol
Albany, New York

Re: LORETTO GERIATRIC CENTER,
Nursing Home

Dear Mr. Goldmark:

The attached certified rate revision is for the above noted institution.

Loretto Geriatric Center's nursing staff was reviewed by the regional office during an on-site inspection. The regional office recommended that costs attributable to current staffing patterns should be allowed. This represents 3.2 hours of nursing care per patient day in the nursing home.

The attached schedule of estimated income and expenses shows that the nursing home will show a $19,799 deficit if this appeal is granted.

The analysis of income and expense was based on a twelve month statement of 1976 costs recently submitted by the facility. The twelve month statement differed from the previously used ten month statement in two respects. The costs in the ten month statement were arbitrarily allocated between the nursing home and health related facility sections by beds whereas the costs on the twelve month statement were allocated on a statistical basis. The ten month statement did not include capital expenditures of $243,000 which represent Bond Anticipation Note interest and operating escrow payments required by the 28-A mortgage.

The gross Medicaid impact of this revision for the period November 1, 1976 through March 31, 1977 is $60,000.

Sincerely,
William F. McCann
William F. McCann
Assistant Commissioner

cc: Dr. Whalen(2)
Dr. Coates
Dr. Cicero
Mr. Giglio
Mr. Meitch

LORETTO GERIATRIC CENTER

RATE REVISION FOR THE PERIOD NOVEMBER 1, 1976 THROUGH DECEMBER 31, 1976

Nursing Home

	From	To
Daily	$ 48.13	$ 50.49
Monthly	$1464.00	$1536.00

RATE REVISION FOR THE PERIOD JANUARY 1, 1977 THROUGH MARCH 31, 1977

	From	To
Daily	$50.10	$52.57

LORETTO GERIATRIC CENTER

Description	Nursing Home	Health Related Facility	Total
Annualized Expense (1)	$ 3,452,231.00	$ 4,695,893.00	$ 8,148,124.00
Annualized Income (2)	3,162,141.00	3,914,114.00	7,076,255.00
Estimated Loss	290,090.00	781,779.00	1,071,869.00
Annualized Other Income (3)	30,299.00	56,269.00	86,568.00
Estimated Loss ( )	(259,791.00)	(725,510.00)	(985,301.00)
Additional Annualized Income (4)	155,052.00	518,738.00	673,790.00
Remaining Loss	(104,739.00)	(206,772.00)	(311,511.00)
Reductions in Staff (5)	84,940.00	206,772.00	291,712.00
Estimated Loss	19,799.00	-0-	(19,799.00)

(1) Expenses for the Period January 1, 1976 through December 31, 1976 as submitted by the facility.

(2) The cost based rates of $48.13 for the Nursing Home, and $31.54 for the Health Related Facility was used to establish this Annualized Income.

(3) The Other Income for the Period January 1, 1976 through December 31, 1976 as reported by the facility.

(4) The appeal for an increase in rate due to Nursing of $2.36 per day in the Nursing Home, and $4.18 per day in the Health Related Facility was annualized.

(5) The Facility on December 16, 1976 notified the Department of Health it had made cuts in staff and services totaling $291,712.00.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

ROBERT P. WHALEN, M.D.
COMMISSIONER

February 17, 1977

Dear Mr. Goldmark:

In accordance with the provisions of Section 2807 of the Public Health Law, I am certifying to you that the proposed rate schedule for payments for medical services at the MARY MANNING WALSH NURSING HOME COMPANY, INC., New York County, for the periods January 1, 1976 through November 30, 1976, December 1 through December 31, 1976, and January 1 through March 31, 1977 are reasonably related to the cost efficient production of such services.

These rates do not reflect adjustments, which will be made to future rates, as the result of a management assessment conducted by this department. The final adjustments in allowable costs are not available at this time.

The formula on which these rates was promulgated in Part 86 of the Commissioner's Administrative Rules and Regulations.

Sincerely yours,

Robert P. Whalen, M.D.
Commissioner of Health

The rates established are hereby approved.

For Peter C. Goldmark, Jr.
Director of the Budget

Attachment

Honorable Peter C. Goldmark, Jr.
Director of the Budget
The State Capitol
Albany, New York

Ex. C

STATE OF NEW YORK ○ DEPARTMENT OF HEALTH
TOWER BUILDING • EMPIRE STATE PLAZA • ALBANY, N.Y. 12237

ROBERT P. WHALEN, M.D.
COMMISSIONER

DIVISION OF HEALTH CARE FINANCING
WILLIAM F. McCANN
ASSISTANT COMMISSIONER

DB

Mr. Peter C. Goldmark, Jr., Director
Division of the Budget
State Capitol
Albany, New York

Re: Mary Manning Walsh Nursing Home Co.
Rate revisions effective January 1, 1976, November 30, 1976 and January 1, 1977

Dear Mr. Goldmark:

The attached rate revisions for the above facility were based on the following:

1. The rating for nursing care used in computing the H.R.F. rates retroactive to January 1, 1976 was successfully appealed from good federal to good state. However in processing the appeal, the recomputation of cost subject to ceilings resulted in a lower rate for the skilled nursing facility.

2. The New York City Regional Office granted the facility temporary approval to convert 30 H.R.F. beds to 30 S.N.F. beds.

Justification for the approval is contained in the accompanying memorandum from the Division of Health Care Standards.

The financial effects of the change in bed capacity results from placing the S.N.F. in a 300 bed and over group with a higher cost ceilings and correspondingly higher rates as well as increasing the number of patients receiving the services at the S.N.F. rates. The impact is somewhat offset by lower ceilings for the H.R.F. and fewer patients receiving services at the H.R.F. rate.

The medicaid impact of the certified rate established as a result of the bed change and processing of the appeal totals $379,667 for the period January 1, 1976 thru March 31, 1977. The computation of the medicaid impact is appended to this letter.

Very truly yours,

Carmine Asparro

Carmine Asparro
Asst. Commissioner for
Health Care Financing
Operations

CC: Dr. Walen (2)
Dr. Coates
Dr. Cicero
Dr. Haughie
Dr. Herdman
Mr. Giglio

MARY MANNING WALSH NURSING HOME COMPANY, INC.

RATE REVISION

Skilled Nursing Facility

	From	To	Period
Daily	$53.48	$52.98	1/1/76-11/30/76
Monthly	$1627.00	$1612.00	
Daily	$53.48	$65.04	12/1/76-12/31/76
Monthly	$1627.00	$1978.00	
Daily	$55.42	$67.46	1/1/77-3/31/77

Health Related Facility

	From	To	Period
Daily	$37.73	$38.40	1/1/76-11/30/76
Monthly	$1148.00	$1168.00	
Daily	$37.73	$37.27	12/1/76-12/31/76
Monthly	$1148.00	$1134.00	
Daily	$39.05	$38.57	1/1/77-3/31/77

MARY MANNING WALSH NURSING HOME COMPANY INC.
MEDICAID IMPACT
Appeal 702002 and bed change

	Medicaid Impact			
	1/1/-11/30/76	12/1/-12/31/76	1/1/-3/31/77	Total
Rate for appeal 702002	($29,861)	($2,715)	($8,386)	
Bed Change				
Change from S.N.F. to H.R.F. Patients		$21,337	$61,586	
Change in rate from change in ceilings		$81,876	$255,830	
	$29,861	$100,498	$309,030	$379,667

STATE OF NEW YORK
DEPARTMENT OF HEALTH

MEMORANDUM

February 15, 1977

To: Carmine Asparro

From: Donald B. Davidoff,

Subject: Mary Manning Walsh Nursing Home - Medicaid Rate Appeal; Management and Patient Assessments

A partial patient assessment in this mixed facility was performed several weeks ago by our New York City Office, the results of which tended to confirm that Walsh presently is caring for more nursing home patients than previously indicated.

As a result of this partial study, a temporary increase in nursing home beds was authorized. Since then, on February 9 and 10, a complete assessment was undertaken for each and every patient at Walsh. The methodology employed consisted of a revised analysis of each patient, listing of the major diagnosis and rating of each patient as to: ambulation, personal care, incontinency, mental status, general care and supervision, and rehabilitation potential. Special problems were also noted.

On the basis of the above approach, it was determined that 314 patients required, and were receiving, skilled nursing home care.

A management assessment was also conducted at Walsh pursuant to our agreement with Judge Griesa in the Nursing Home Federal Class Action. In excess of $1 million in suggested program revisions were identified. However, two major facts indicate that we must revise our recommendations. The recent patient assessment may well render some of our proposals inappropriate. Secondly, the management assessment was one of the first conducted. It relied on a May 1976 survey as the base line. Much has changed at Walsh since then.

Therefore, we can not insist on cost revisions as this time. Further refinement is necessary and will take place. However, we also note the following progress: 1974 Full Time Equivalent = 414.5; 1975 F.T.E.=370.7; 1976 F.T.E.=340.7. We intend to help make further reductions in 1977.

In the meantime, we recommend that rates be calculated on the basis of 314 nursing home patients.

/kd

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH BULLA, ANNY ALTMAN, NATALIE WARTENBERG, SIGMUND RINGER, DORA GOLDMAN, ANNE MORRIS, TERESA TALIERCIO and DOROTHY NIEMITZ, on behalf of themselves and all other persons similarly situated,
Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,
Defendants.

78 CIV 472

COMPLAINT
(Class Action)

PRELIMINARY STATEMENT

1. This is a class action for declaratory and injunctive relief to redress violations of rights secured to plaintiffs by the due process clause of the Fourteenth Amendment to the Constitution of the United States; by Title XIX (Medicaid) of the Social Security Act, 42 U.S.C. §1396 et seq., and by certain regulations promulgated thereunder; and by the Civil Rights Act of 1871, 42 U.S.C. 1983. This action is brought by and on behalf of nursing home patients whose nursing home care is paid for, entirely or in part, by the Medical Assistance (Medicaid) program established pursuant to Title XIX of the Social Security Act. Plaintiffs allege that their right to due process of law and their rights under Title XIX of the Social Security Act and pertinent regulations have been violated by the defendants' failure to provide them with timely and

adequate prior notice of and an opportunity to contest, any proposed reductions in their Medical Assistance benefits. Plaintiffs also allege that their rights under Title XIX of the Social Security Act and pertinent regulations have been violated by defendants' actions reducing their nursing home care and services below that level required by law and regulations and endangering their lives and health.

JURISDICTION

2. Jurisdiction is conferred upon this Court by 28 U.S.C. §1331 and 28 U.S.C. §1343(3) and (4). The amount in controversy, exclusive of interests and costs, exceeds $10,000. Declaratory relief is authorized by 28 U.S.C. §2201 and 2202, and Rule 57 of the Federal Rules of Civil Procedure.

PLAINTIFFS

3. Plaintiff JOSEPH BULLA is 56 years old and is a patient of the Margaret Tietz Center for Nursing Care, Inc., located at 175-11 Chapin Parkway, Jamaica, N.Y. Mr. Bulla has resided at Margaret Tietz for over four years. He receives skilled nursing care.

4. Plaintiff ANNY ALTMAN, M.D., is 84 years old and a patient at the Margaret Tietz home. Dr. Altman has resided at Margaret Tietz for approximately one year. Prior to that time she was a resident of St. Cabrini Nursing Home, Inc., of Dobbs Ferry, New York. She receives intermediate care.

5. Plaintiff NATALIE WARTENBERG is 61 years old and a patient at the Margaret Tietz home. Ms. Wartenberg has resided at Margaret Tietz for over two years. She receives intermediate care

6. Plaintiff SIGMUND RINGER is 89 years old and a patient at the Margaret Tietz home. Mr. Ringer has resided at Margaret Tietz for over one year. He receives intermediate care.

7. Plaintiff DORA GOLDMAN is 75 years old and a patient at the Margaret Tietz home. Ms. Goldman has resided at Margaret Tietz for over one year. She receives intermediate care.

8. Plaintiff ANNE MORRIS is 72 years old and is a patient at the Beth Abraham Hospital, a Skilled Nursing Facility located at Allerton Avenue at Bronx River Parkway, Bronx, New York. She has been a patient of Beth Abraham for nearly 14 years.

9. Plaintiff TERESA TALIERCIO is 60 years old and is a patient at Beth Abraham Hospital. She has been a patient at Beth Abraham for nearly 4 years.

10. Plaintiff DOROTHY NIEMITZ is 64 years old and a patient at Beth Abraham Hospital. She has been a patient at Beth Abraham for 11 1/2 years.

CLASS ACTION ALLEGATIONS

11. The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a) and (b)(2) of the Federal Rules of Civil Procedure, on behalf of all nursing home residents in the State of New York receiving assistance under Title XIX of the Social Security Act (Medicaid) who have suffered or are threatened with a reduction or termination

of assistance without having been afforded adequate and timely notice of the reduction or termination and an opportunity for a hearing to contest the reduction. This class includes those patients whose level of care has been or will be reduced below that level required by law as well as any patients whose reduced level of care will continue to satisfy minimal requirements.

12. The class is so numerous that joinder is impracticable. Upon information and belief there are more than 70,000 members of the plaintiffs' class. There are questions of law and fact which are common to the entire class. The claims of the representative plaintiffs are typical of the claims of the class. The representative plaintiffs are qualified to and will adequately protect the interests of the class. In addition, the defendants have acted or failed to act on grounds generally applicable to the class as a whole, thereby making appropriate final injunctive and declaratory relief with respect to the class as a whole.

DEFENDANTS

13. Defendant PHILIP L. TOIA is the Acting Commissioner of Social Services of the State of New York. In that capacity he is responsible for the administration of the Medical Assistance (Medicaid) program in the State of New York.

14. Defendant ROBERT A. WHALEN, M.D., is the Commissioner of Health of the State of New York. In that capacity

he has responsibility for and authority to promulgate regulations establishing the method and rates of reimbursement paid to nursing homes under the Medicaid program for the plaintiffs' nursing care.

15. Defendant PETER GOLDMARK is the Director of the Budget of the State of New York. In that capacity he has responsibility for approving Medicaid reimbursement rates determined and certified to him by the Commissioner of Health.

16. Defendant HUGH L. CAREY Is the Governor of the State of New York. The Governor is the chief executive officer of the State of New York and is responsible for the administration of all laws, policies and programs of the State, including the Medical Assistance program, required by law and necessary to insure the health and safety of the patients.

NEW YORK'S RESIDENTIAL HEALTH CARE FACILITIES AND THE FEDERAL-STATE MEDICAID PROGRAM

17. Residential health care facilities in the State of New York, commonly referred to as "nursing homes", provide long-term care to elderly residents of the State which includes a combination of nursing services, life-sustaining medical treatment, recreational activities, social services, therapy, lodging and board that is unavailable to such residents from other sources.

18. Depending upon the degree of medical care and services rendered, residential health care facilities are

classified as either "intermediate care facilities" (sometimes referred to as "health related facilities") or "skilled nursing facilities".

19. At the present time approximately 70,000 elderly residents of the State of New York are patients in residential health care facilities in the State.

20. In 1965 the United States Congress passed Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. (the Medicaid Act), which provided for payment of federal funds to states willing to make similar payments for the purpose of furnishing medical assistance to aged individuals whose resources were insufficient to meet the costs of necessary health care. Among the services for which federal funds were made available were the services provided by residential health care facilities.

21. In order for a state to avail itself of the federal funds appropriated under the Medicaid Act, it is first required by Section 1901 (42 U.S.C. 1396) of that Act to submit for approval to the Secretary of Health, Education and Welfare (hereinafter "HEW") a "State plan" for medical assistance which meets the requirements for such plans set forth in Section 1902 (42 U.S.C. 1396a) of the Medicaid Act.

22. In 1966, the New York Legislature enacted Title 11 of the Social Services Law, Sections 363-369, (hereinafter "Title 11") which, among other things, directed the Department of Social Services to submit a plan for medical assistance on behalf of New York (hereinafter the "New York State Plan"). The New York State Plan was submitted to and approved by

HEW in 1966. At all times since 1966 the New York State Plan has provided, among other things, for payment to residential health care facilities for services rendered to Medicaid-sponsored patients. As a result of the adoption of the New York State Plan, and its approval by the Secretary of HEW, the federal government reimburses the State of New York for 50% of the total amount spent by the State and localities for services rendered to Medicaid-sponsored patients.

23. Pursuant to Section 363-a of Title 11, the Department of Social Services is the "single state agency" required by Section 1902(a) (42 U.S.C. 1396(a)) of the Medicaid Act to supervise the administration of the New York State Plan. By virtue of a "Cooperative Agreement" between the Department of Social Services and the Department of Health, the Department of Health is responsible for administering and supervising the medical care and health services available to Medicaid-sponsored patients, including the services provided by residential health care facilities.

24. In order for a residential health care facility to become eligible for reimbursement for services to Medicaid-sponsored patients it must:

(A) be certified by the Department of Health as being in compliance with the federal Medicaid standards applicable to such facilities, as those standards are defined in 45 C.F.R. §249.33; and

(B) sign a Medicaid Provider Agreement with the Department of Social Services which provides that the

Department of Social Services will, for the twelve-month period set forth in the Agreement, make payments for services provided by the residential health care facility to Medicaid-sponsored patients so long as such facility continues to be in compliance with applicable federal Medicaid standards.

REIMBURSEMENT OF RESIDENTIAL HEALTH CARE FACILITIES FOR SERVICES RENDERED TO MEDICAID-SPONSORED PATIENTS

Federal Provisions

25. The Medicaid Act, as enacted in 1965, did not provide any minimum reimbursement standard for residential health care facilities for services rendered to Medicaid-sponsored patients. Each state was permitted to determine its own reimbursement rates for such services, constrained only by the federal requirement that the rate not exceed certain upper limits.

26. In cases where a state's rate failed to reimburse residential health care facilities for the full costs incurred in rendering services to Medicaid-sponsored patients, the state plan for medical assistance was permitted to include a "supplementation program", under which additional payments could be secured from a patient's friends or relatives who were not otherwise legally obligated to contribute to the patient's support, or from the patient's own otherwise exempt income or resources.

27. In 1972 Congress amended the Medicaid Act by the addition of 42 U.S.C. §1396a(13)(E), which provided that,

effecitve July 1, 1976, a state plan for medical assistance must provide reimbursement to residential health care facilities "on a reasonable cost related basis...."

28. Concurrent with the effective date of 42 U.S.C. §1396a(13)(E), the federal regulations permitting supplementation programs were deleted and the last state plan for supplementation of payments to residential health care facilities was scheduled to conclude. All providers of residential health care services in the United States are now required to accept Medicaid reimbursement as payment in full for such services rendered to Medicaid-sponsored patients.

State Provisions

29. At all times relevant hereto prior to March 30, 1976, the reimbursement rates to be paid to residential health care facilities in New York State providing services to Medicaid-sponsored patients were set pursuant to §2807 of the New York Public Health Law.

30. Pursuant to Public Health Law §2807(3), the Commissioner of Health was required to determine nursing home reimbursement rates and certify them to the Director of the Budget. Prior to the approval of such rates by the Director of the Budget, the Commissioner was required to certify that the rates were "reasonably related to the costs of efficient production of...[health care] service."

31. In order to assure that the rates set by the Commissioner of Health were, in fact, "reasonably related to the costs of efficient production", Public Health Law §2807(3)

directed the Commissioner of Health to take into consideration in determining reimbursement rates "the elements of cost, geographic differential in the elements of cost considered, economic factors in the area in which the...[facility] is located...[and] the rate of increase or decrease of the economy in the area in which the...[facility] is located...."

32. Pursuant to Public Health Law §2807(3), the Commissioner of Health, with respect to all relevant fiscal years prior to the fiscal year beginning January 1, 1976, determined rates in accordance with the method contained in rules and regulations codified as Part 86 of 10 N.Y.C.R.R. (hereinafter "Part 86").

The August 1975 Amendments to the Public Health Law

33. In August 1975, the Legislature enacted amendments to Article 28 of the Public Health Law, which, among other things, directed the Commissioner of Health to establish criteria for the evaluation of residential health care facilities and directed him to devise, based upon inspections by the Department of Health, a rating system for such facilities "in accordance with the deficiencies and areas of significantly high care and performance which the reports of inspections shall have indicated." (Public Health Law §2803(1)(c)).

34. Upon information and belief, subsequent to the enactment of the August 1975 Amendments to the Public Health Law, the Commissioner of Health began to devise a system for rating residential health care facilities on the basis of

their compliance with the provisions of the State Hospital Code, 10 N.Y.C.R.R. §700 et seq. The inspections to be conducted pursuant to such system, and the ratings to be assigned thereunder, were designed solely to apprise the public of the quality of such facilities and were not designed to determine, and did not take into account, the reasonable costs incurred by the inspected facilities in providing health care services to their patients.

The "Freeze" of Reimbursement Rates at 1975 Levels

35. Pursuant to Public Health Law §2807(4), the Commissioner of Health was required to notify residential health care facilities of their approved 1976 reimbursement rate sixty days prior to the fiscal year for which such rates were effective, i.e., no later than November 1, 1975.

36. On or about October 31, 1975, the Department of Health issued a "Hospital Memorandum" dated October 31, 1975, advising that:

(A) Each residential health care facility has "been directly notified of its Medicaid reimbursement rates for the period January 1, 1976 through December 31, 1976";

(B) "The individual rates for each health facility were developed on an interim basis"; and

(C) "New legislation concerning 1976 reimbursement, and still unresolved aspects of Part 86...have made it impossible to promulgate final health facility rates at this time."

37. In fact, the reimbursement rates of which residential

health care facilities were notified in accordance with the Hospital Memorandum of October 31, 1975 were no more than a restatement of their 1975 rates, the effect therefore being to "freeze" Medicaid reimbursement rates.

38. On information and belief, during the period from the approval of the 1975 reimbursement rates to the time that new rates for 1976 should have been determined, the costs of operating a residential health care facility increased substantially as a result of the general inflationary movement of the economy.

39. Since the 1975 reimbursement rates had been promulgated to reimburse residential health care facilities for their reasonable costs of providing services to Medicaid-sponsored patients during 1975, reimbursing these facilities at those same rates for 1976 Medicaid services necessarily resulted in reimbursement to residential health care facilities of less than their reasonable cost of providing services to Medicaid-sponsored patients, in disregard of the statutory mandate of Public Health Law §2807(3). Beginning in January, 1976, in order to accommodate the "frozen rates" the nursing homes in New York State reduced the services provided to plaintiffs.

40. In an action commenced to challenge the "frozen" reimbursement rates, it was determined that such rates necessarily failed to reimburse residential health care facilities for their 1976 reasonable costs, in violation of, among other things, Public Health Law §2807(3). Kaye v. Whalen, N.Y. Sup. Ct. Albany Co. (Staley, J.), decided

September, 1976 (appeal pending).

Chapter 76 of the
Laws of 1976

41. By Chapter 76 of the Laws of 1976, effective March 30, 1976 (hereinafter "Chapter 76"), the New York State Legislature attempted to validate the "freeze" imposed by the Commissioner of Health as of January 1, 1976 by providing that in setting rates for 1976 the Commissioner might disregard the requirement of Section 2807(3) of the Public Health Law that rates be "reasonably related to the cost of efficient production" of health care services (Chapter 76, §11, adding Section 2807(2)(c) *et seq.* to the Public Health Law).

42. In addition, in an attempt to decrease or at least prevent an increase in the State Medicaid expenditures, Chapter 76 directed the Commissioner of Health to formulate residential health care facility Medicaid rates for the period ending March 31, 1977, which rates would be based upon ratings received pursuant to the rating system the Commissioner of Health had been directed to devise pursuant to the August 1975 amendments to the Public Health Law. (Chapter 76, §11).

43. On or about March 24, 1976, subsequent to the enactment of Chapter 76 but before the Governor signed it into law, the Commissioners of Health and Social Services advised the Governor's counsel that the rating system being formulated pursuant to the August 1975 amendments was being put into effect but that it would "take a full year before all residential health care facilities are individually rated."

44. Moreover, the Commissioners of Health and Social Services acknowledged to the Governor's counsel that by directing the formulation of reimbursement rates based upon a rating system, without regard to costs, Chapter 76 raised "the possibility that there will be a federal compliance issue as of July 1, 1976 since, as of that date, federal requirements mandate that nursing home rates be formulated on a cost related basis."

45. Notwithstanding the fact that there existed no adequate rating system based on current inspections, and that the rating system that was being implemented was not designed to take into account either intensity of care or the reasonable cost thereof, Chapter 76 was signed into law on March 30, 1976, thereby directing the Commissioner of Health to formulate reimbursement rates in accordance with the rating system.

46. That the purpose of Chapter 76 was to limit Medicaid reimbursement rates is confirmed by the Governor's message, delivered on March 31, 1976, upon approval of Chapter 76. The Governor noted that both the Commissioners of Health and Social Services advised the Governor that they had "serious reservations" about the bill but "the expenditure savings projected under the bill are essential to achieve a balanced budget, and because of that urgent need to present such a budget for the State of New York, I must sign this measure into law."

The Use of the Rating System to Limit Reimbursement

47. Between April 1 and May 13, 1976, purporting to follow the directive of Chapter 76, the Department of Health conducted a "crash" program designed to establish "ratings" for every residential health care facility in the state, for the purpose of utilizing such ratings to limit Medicaid reimbursement rates.

48. The ratings were based upon reports of Department of Health surveyors who inspected the facilities, but because the implementation of new rates under Chapter 76 required immediate ratings, the surveys upon which those ratings were based:

(A) were for the most part out of date, and failed in many instances to reflect changes in operations of facilities and corrections of deficiencies, if any, that had occurred between the survey and the rating; and

(B) had nothing whatever to do with an analysis of the cost of providing the services rendered.

49. On or about May 13, 1976, each residential health care facility received a "Nursing Home Rating Certificate", which rated the facility on its "Building Features" and seven types of services:

(A) Nursing
(B) Food-Nutrition
(C) Leisure Time Activities
(D) Cleanliness and Safety
(E) Medical Care
(F) Rehabilitation Therapy
(G) Social Work

50. The five "ratings" developed by the Department of Health for rating the services inspected were:

(A) "Very Good",

(B) "Good State",

(C) "Good Federal",

(D) "Needs Improvement", and

(E) "Unacceptable".

51. Although the rating system was purportedly based on objective standards, the actual ratings of a residential health care facility's services were based on totally subjective, vague and non-reviewable criteria.

52. For example, the meaning of "Very Good", as formulated by the Department of Health, was as follows:

> Very Good means - The facility conforms fully with the intent and content of State Hospital Code requirements, provides the type of service being rated by clearly superior methods and with clearly superior results, provides the service efficiently and economically, and is in the vanguard of its class of facilities in the jurisdiction in which located.

53. The "Very Good" rating definition establishes a comparative standard by requiring that a nursing home be "in the vanguard of its class of facilities" in order to receive a "Very Good" rating for a particular service. This necessarily limits the number of homes which can achieve this rating and thus be adequately reimbursed for the costs of providing care to plaintiffs.

54. Upon information and belief, employees of the

Department of Health were advised that it was anticipated that only 20 to 30 residential health care facilities, of all those located in the State, would receive what was ultimately developed as the "Very Good" rating in most or all of the services rated, and that what ultimately was developed as the "Good-State" rating would be "reserved" for those facilities that performed "well above the average" level in any category but that still "could not be documented as furnishing an obviously superior kind of service."

65. Although residential health care faciltiies were permitted to "appeal" ratings in the individual services received by them on or about May 13, 1976, the plaintiffs were not given notice of the rating of their homes and that the homes' reimbursement rate would be dependent thereon.

56. Having developed the rating system as set forth above, and in accordance with the legislative mandate to reduce Medicaid expenditures, the Department of Health proceeded to develop "regulations" designed to relate the rating system to reimbursement rates.

57. Upon information and belief, in devising regulations designed to reduce reimbursement rates, the Department of Health adopted the following approach:

(A) Residential health care facilities were grouped in 5 categories solely according to the number of beds in the facility (the smallest group being 50 beds and under and the largest being over 300 beds).

(B) Having grouped the facilities as above, the facilities within each group were further identified by the rating which they received in each of the categories of nursing, food-nutrition, leisure time activities, cleanliness, and safety, and social work. For example, all facilities with a capacity of between 100 and 199 beds which received a "Good-State" rating in nursing, were grouped together; and

(C) Having thus identified and grouped the homes by bed size and rating for each service, it was determined what ceiling on reimbursement for each service was required in order to assure that the total expenditure for Medicaid reimbursement for residential health care facilities in 1976 would meet budget requirements predetermined by defendants.

58. The required ceilings on reimbursement were ultimately imposed by subjecting all facilities other than those receiving a "Very Good" rating for a particular service to a reimbursement ceiling based upon a "percentile system", as follows:

(A) Facilities receiving a "Good-State" rating for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 60th percentile of all facilities in the group.

(B) Facilities receiving "Good-Federal" ratings for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 35th percentile of all facilities which received a "Good-State" rating for such service.

(C) Facilities receiving "Needs-Improvement" ratings for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 25th percentile of all facilities which received a "Good-State" rating for such service.

59. In other words, some part of the actual costs incurred by 40% of the facilities receiving a Good-State rating for any service were disallowed in determining the Medicaid reimbursement for such service, regardless of the needs of the patients, the reasonableness of the cost incurred in providing the service, or the efficiency of its production. Similar exclusions occurred with respect to costs incurred by all facilities above the percentile limitation in each category.

60. Upon information and belief, the particular percentile which served as the basis for limiting reimbursement was selected not because it bore any relationship to the reasonable costs of the services necessary, but because the ultimate formulation of percentiles yielded the dollar amount to which defendants had determined to limit total Medicaid reimbursement for residential health care facilities.

61. Upon information and belief, defendants considered - and rejected - a variety of higher percentile limitations other than those ultimately chosen, because such higher limitations would not have yielded the predetermined overall Medicaid reimbursement figure to which they considered themselves limited.

Promulgation of the Challenged Regulations and Rates

62. On September 30, 1976, the defendant Commissioner of Health promulgated new regulations, "Part 88" of 10 N.Y.C.R.R., entitled "Reporting and Rate Certification for Residential Health Care Facilities" embodying the method of reimbursement related above. Part 88 purported to require the calculation of Medicaid reimbursement rates retroactively to January 1, 1976.

63. The Commissioner of Health purported to make the adoption of Part 88 effective immediately.

64. On October 12, 1976 the Department of Health gave notice of adoption of Part 86-2 of 10 N.Y.C.R.R., (hereinafter "Part 86-2"), pursuant to the provisions of the Administrative Procedure Act authorizing promulgation of such rules only after notice and a comment period of 21 days. Part 86-2 is in all material respects the same as Part 88.

65. Prior to the end of the 21 day notice and comment period, on or about October 26, 1976, the Office of the Director of the Budget announced that it had approved "1976 Medicaid reimbursement rates", retroactive to January 1, 1976, certified to it by the Commissioner of Health. It is unclear whether the calculation of such rates by the Commissioner of Health was pursuant to Part 88 or to the provisions of the not-yet adopted Part 86-2.

66. The plaintiffs were not given notice of the defendants' actions, either prior to or after the date they became effective.

67. On information and belief, the Department of Health announced at a hearing before Honorable Thomas P. Griesa that it had calculated new Medicaid reimbursement rates. The present status of this rate schedule is uncertain but, on information and belief, the Department intends to make these rates effective January 1, 1977.

68. Plaintiffs were not given notice of the defendants' actions prior to the date they were to become effective and, on information and belief, defendants have no plan to give notice of these or any subsequent similar actions to the plaintiffs.

69. The "1976 Medicaid reimbursement rates" were in many cases substantially lower than the 1975 "frozen" rates.

70. On information and belief, the 1977 Medicaid reimbursement rates were generally calculated by applying a 4 1/2% increase to the operating cost portions of rates given in the "1976 Medicaid reimbursement rates". In many cases, the 1977 Medicaid reimbursement rates still fall below the 1975 "frozen" rates and no 1977 Medicaid reimbursement rates reach the level of the 1975 rates adjusted for intervening inflation.

EFFECT OF THE CHALLENGED RATES

71. The prospective impact of the reductions from 1975 rates on individual plaintiffs, described hereafter, is representative of the impact on the plaintiff class.

72. The Medicaid payment to Margaret Tietz Nursing Home on behalf of JOSEPH BULLA and other plaintiffs under skilled care will be reduced from $71.26 per day per patient to $51.38 for November and December 1976 and to $53.22 beginning January, 1977.

73. The Medicaid payment to Margaret Tietz Nursing Home on behalf of ANNY ALTMAN, NATALIE WARTENGERG, SIGMUND RINGER, and DORA GOLDMAN and other plaintiffs under intermediate care will be reduced from $41.32 per patient per day to $35.08 for November and December, 1976 and to $36.87 beginning January, 1977.

74. In testimony before Honorable Thomas P. Griesa in the action entitled New York Association of Homes for Aging, Inc. against Toia, 76 Civ. 5113, on December 10, 1976, Dr. Frank Cicero, Deputy Commissioner of the defendant New York State Department of Health, stated that Margaret Tietz Center for Nursing Care could accommodate the cuts in reimbursement by firing four administrative personnel, two and one-half clerical workers, eight registered nurses, three licensed practical nurses, twenty nursing aides, one assistant director of nursing, two nursing supervisors, one and one half secretaries, one dietetic technician, two food service aides, one social worker, five housekeeping aides and three laundry aides.

75. The Medicaid payment to Beth Abraham Hospital on behalf of ANNE MORRIS, TERESA TALIERCIO, DOROTHY NIEMITZ and the other patients of Beth Abraham will be reduced from

$66.00 per day per patient to $59.47 for November and December, 1976 and to $61.93 beginning January, 1977.

76. This rate change will result in a total reduction of reimbursement of nearly $750,000 to the home per year.

77. On or about January 17, 1977 the New York State Department of Health informed Beth Abraham of additional cuts the Department intended to make in Beth Abraham's budget. The cuts imposed on January 17, 1977 totalled nearly $3,000,000. It is unclear whether these cuts are to be imposed in addition to the $750,000 or whether they include the prior cuts.

78. In a document prepared by the defendant New York State Department of Health for presentation to Honorable Thomas P. Griesa in the action entitled New York Association of Homes for Aging, Inc. et al against Toia, 75 Civ. 5113 the department states that Beth Abraham could accommodate the imposed cuts by firing the Assistant Director, the Fiscal Coordinator, the entire admitting department, the entire personnel department, three bookkeepers, 77 nursing supervisors, 30 nurses aides, the Director of Food Service, 62 Housekeeping positions, 3.1 laundry aides, 9 maintenance workers, 2 drivers, 15 social workers, and 1 group worker. In addition, the Department wishes to convert 65.8 Registered Nurse positions to Licensed Practical Nurse positions and close the Sheltered Workshop.

79. The Medicaid payment to St. Cabrini Nursing Home in Dobbs Ferry on behalf of approximately 150 members of plaintiff class will be reduced from $62.51 per patient per day to $55.06 for November and December 1976 and to

$57.29 beginning January, 1977.

80. The Medicaid payment to Daughters of Sarah Nursing Home in Albany on behalf of approximately 180 members of plaintiff class will be reduced from $50.92 per patient per day to $44.70 for November and December 1976 and to $46.43 beginning January, 1977.

81. If the proposed new rates are implemented, wholly apart from any retroactive application of such rates, members of the plaintiff class will have the quality and amount of their care reduced to accommodate the lower reimbursement rate.

Retroactive Application

82. Defendants claim that each nursing home which has had its Medicaid reimbursement rate reduced is required to remit to defendants the difference between the amount each such facility received pursuant to its prior reimbursement rate and the amount it would have received had the new rate been in effect as of January 1, 1976.

83. The nursing homes in which members of the plaintiff class reside are now being required to repay defendants enormous sums, with certain facilities owing defendants in excess of $1,000,000. The impact of the retroactive application of the new rates on the individual plaintiffs is representative of the impact on the plaintiff class.

84. If the new rates were applied retroactively from January 1, 1976, as of October 31, 1976 Margaret Tietz would owe approximately $600,000. Beth Abraham would owe approximately

$2,000,000.

85. Upon information and belief, defendants intend to withhold prospective Medicaid reimbursement payments to Margaret Tietz, Beth Abraham and other affected homes to the extent necessary to "recoup" the amounts now claimed to be owed. If defendants are permitted to withhold prospective Medicaid reimbursement payments, or otherwise to effect the repayment of the amount claimed to be owed, it will lead to immediate further reductions in the amount and quality of care rendered to plaintiffs. Similarly thousands of elderly patients in the State of New York will be immediately deprived of essential life-sustaining health care services if the homes in which they reside are required to remit amounts sought by the defendants.

ROLE OF MEDICAL ADVISORY COMMITTEE

86. The Medicaid regulations, 45 C.F.R. §246.10(a)(3), require that an approved state plan for medical assistance provide for a "Medical Care Advisory Committee", which "will have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program of the agency."

87. The New York State Plan provides for a Medical Advisory Committee as required by 45 C.F.R. §246.10, and New York Social Services Law §365-c(2) provides that the Medical Advisory Committee" shall advise the Commissioner [of Social Services] with respect to [Medicaid] health and

medical care services", and requires that the committee meet at least once a year.

88. The Medical Advisory Committee has not met within the past year and was not consulted about the adoption or implementation of Parts 88 or 86-2 or the rates calculated thereunder, in violation of 45 C.F.R. §246.10 and New York Social Services Law §365-c(2).

FIRST CAUSE OF ACTION

89. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 88 above, as if fully set forth herein.

89. Defendants' actions have reduced and threaten to reduce plaintiffs' Medical Assistance benefits without providing to plaintiffs any notice of said actions and without providing plaintiffs opportunity for a hearing, in violation of plaintiffs' rights to due process of law under the XIV Amendment and their rights under Title XIX of the Social Security Act and pertinent regulations, including 45 C.F.R. Section 205.10, and under 18 N.Y.C.R.R. 358.4(a) and 18 N.Y.C.R.R. 358.8.

SECOND CAUSE OF ACTION

90. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 88 above, as if fully set forth herein.

91. The Medicaid regulations require that an approved state plan for medical assistance provide for a "Medical

Care Advisory Committee," which is to include "Members of consumer groups including Title XIX recipients,....," 45 C.F.R. §246.10(a)(2)(ii), and is to "have adequate opportunity for meaningful participation in policy development and program administration, including the furtherance of recipient participation in the program of the agency." 45 C.F.R. §246.10(a)(3).

92. Upon information and belief, the Medical Advisory Committee has not met within the past year and was not consulted about the adoption of implementation of Parts 88 or 86-2 or the rates calculated thereunder, in violation of 45 C.F.R. §246.10 and New York Social Services Law §365-c(2).

93. By reason of the foregoing, Parts 88 and 86-2 and the rates calculated thereunder are invalid.

THIRD CAUSE OF ACTION

94. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 88 above, as if fully set forth herein.

95. The rating system upon which Medicaid reimbursement rates are based depends upon such subjective evaluations as whether the facility rated conforms with "the intent" of the State Hospital Code, provides the service being rated by "clearly superior methods" and with "clearly superior results," and is in the "vanguard of its class of facilities in the jurisdiction in which it is located."

96. Because Parts 88 and 86-2, and the rates calculated thereunder, are based upon a method that groups facilities solely by number of beds, without regard to geographic location or the degree of care required by the patients in a particular facility, and imposes reimbursement ceilings based upon a percentile system designed solely to limit reimbursement rather than measure reasonable costs, Parts 88 and 86-2, and the rates calculated thereunder, do not rationally relate to the needs of plaintiff nursing home patients.

97. By reason of the foregoing, the rating system is vague, unreasonable, arbitrary and capricious, and Parts 88 and 86-2, and the rates calculated thereunder insofar as they base Medicaid reimbursement upon the rating system, are invalid under the due process clauses of the Fifth and Fourteenth Amendments to the United States Constitution and the common law of New York State.

FOURTH CAUSE OF ACTION

98. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1 through 88 above, as if fully set forth herein.

99. The Medicaid Act and regulations promulgated thereunder and New York State law and pertinent regulations set certain minimum standards for the delivery of residential health care services. Because the reductions in the Medicaid reimbursement rate will result in a lowering of

the plaintiffs' medical and nursing care and services below that level required by the Medicaid Act and pertinent regulations and state law, defendants' actions violate the Act, 42 U.S.C. 1396 et seq., the regulations promulgated thereunder, and New York State law and regulations.

FIFTH CAUSE OF ACTION

100. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1 through 88 as if fully set forth herein.

101. The Medicaid Act, specifically 42 U.S.C. 1396a (13)(E) require that residential health care facilities be reimbursed for services rendered to Medicaid-sponsored patients on a "reasonable cost related basis."

102. Because Parts 88 and 86-2 fail to provide for reimbursement to residential health care facilities for services rendered to Medicaid-sponsored patients on a "reasonable cost related basis", as required by 42 U.S.C. §1396a (13)(E), those regulations and the rates calculated pursuant thereto violate 42 U.S.C. §1396a(13)(E) and are invalid thereunder and by reason of the Supremacy Clause of the United States Constitution, Article VI, Clause 2.

SIXTH CAUSE OF ACTION

103. Plaintiffs repeat and reallege each and every allegation contained in paragraphs 1 through 88 as if fully set forth herein.

104. The Medicaid Provider Agreements executed between residential health care facilities and the Department of Social Services constitute one-year contracts pursuant to which the Department of Social Services is obligated, in consideration of each facility's agreeing to comply with federal Medicaid standards and to accept and render service to all Medicaid-sponsored patients, to reimburse each facility for the reasonable costs of such services.

105. Plaintiffs are third party beneficiaries of the contracts between the nursing homes and the Department of Social Services.

106. Because Parts 88 and 86-2, and the rates calculated thereunder necessitate reductions in the level of care and services provided to the plaintiffs below that required to be rendered pursuant to the Medicaid Provider Agreements, such regulations and rates are in violation of (i) the Medicaid Provider Agreements themselves and (ii) Article I Section 10 of the United States Constitution, which prohibits the enactment of any law impairing the obligation of contracts.

SEVENTH CAUSE OF ACTION

107. Plaintiffs repeat and reallege the allegations set forth in paragraphs 1 through 88 above, as if more fully set forth herein.

108. 45 C.F.R. §250.30(a)(7) requires that state plans for medical assistance:

> Provide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

109. Because Parts 88 and 86-2, and the rates calculated do not provide reimbursement to residential health care facilities for the reasonable costs to such facilities in providing care to Medicaid-sponsored patients, Parts 88 and 86-2 are not designed to enlist participation in the Medicaid program, the result of which will be to deprive eligible persons of skilled nursing and intermediate care services which are among the medical services guaranteed to Medicaid-eligible patients under the New York State Plan. Plaintiffs also will be denied the opportunity to freely choose the home in which they desire to reside.

110. By reason of the foregoing, Parts 88 and 86-2 and the rates calculated thereunder, as well as Chapter 76 insofar as it directs or authorizes such regulations and rates, violate the Medicaid Act and regulations, and are invalid thereunder and by reason of the Supremacy Clause of the United States Constitution, Article VI, Clause 2.

111. Plaintiffs have no adequate remedy at law.

112. Plaintiffs and members of the plaintiff class will suffer immediate irreparable injury unless the defendants

are preliminarily and permanently enjoined from (i) reducing retroactively the rates calculated under Parts 88 and 86-2, (ii) applying prospectively Parts 88 and 86-2 and the rates calculated thereunder and (iii) reimbursing the residential health care facilities in which plaintiffs and the members of the plaintiff class reside at less than their reasonable costs in rendering services to plaintiffs.

WHEREFORE, plaintiffs pray that

(1) This Court declare and adjudge that:

(A) The defendants' reduction of plaintiffs' Medical Assistance benefits without providing plaintiffs notice and an opportunity for a hearing is a violation of:

(i) the due process clause of the Fourteenth Amendment to the Constitution of the United States;

(ii) Title XIX of the Social Security Act, 42 U.S.C. 1396 _et_ _seq_.;

(iii) 45 C.F.R. §205.10; and

(iv) 18 N.Y.C.R.R. §§358.4(a) and 358.8.

(B) The reduction in plaintiffs' Medical Assistance benefits without the prior consultation and participation of the Medical Advisory Committee is a violation of:

(i) 45 C.F.R. §246.10(a) and

(ii) New York Social Services Law §365-c(2).

(C) The rating and reimbursement system established by Parts 88 and 86-2 are in violation of:

(i) the due process clause of the Fifth and Fourteenth Amendments to the Constitution of the United States;

(ii) Article I, Section 10 and Article VI, Clause 2 of the United States Constitution;

(iii) the Medicaid Act, specifically 42 U.S.C. §§1396a(13)(E) and 1396(a)23;

(iv) the Medicaid Provider Agreements between the residential health care facilities in New York and the Department of Social Services; and

(v) 45 C.F.R. §§249.20 and 250.30(a)(7).

(D) The reductions in plaintiffs' nursing care and services required to accommodate the reimbursement reductions imposed by the defendants violates:

(i) the Medicaid Act, 42 U.S.C. 1396 et seq. and regulations pertaining thereto;

(ii) Article I, Section 10 of the United States Constitution;

(iii) New York Social Services Law and Health Code; and

(iv) the Medicaid Provider Agreement.

(2) This Court preliminarily and permanently enjoin the defendants and their successors, officers, agents, servants, employees and attorneys from:

(A) Applying or attempting to apply Parts 88 or 86-2, or the rates calculated thereunder, to any residential health care facility for services rendered to plaintiffs.

(B) Attempting to collect, directly or by set-off, any sums of money from residential health care facilities with respect to services rendered to Medicaid-sponsored patients at any time prior to the entry of an order or judgment in this action.

(3) This Court order the defendants and their successors, officers, agents, servants and employees:

(A) To compute Medicaid reimbursement rates designed to reimburse residential health care facilities sufficient sums to insure the provision of nursing care and services to which the plaintiffs are entitled by law.

(B) Consult with and allow the participation of the Medical Advisory Committee in the development of any Medicaid reimbursement sales.

(4) Plaintiffs be awarded their costs and such other and further relief as to this Court may seem just and proper.

ANDREW P. ZWEBEN
Legal Services for the Elderly Poor
2095 Broadway, Room 304
New York, NY 10023
(212) 595-1340

Stephen M. Jacoby
STEPHEN M. JACOBY
American Jewish Congress
15 East 84 Street
New York, NY 10028
(212) 879-4500

Attorneys for Plaintiffs

DATED: New York, New York
January 26, 1977

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH BULLA, ANNY ALTMAN, NATALIE WARTENBERG, SIGMUND RINGER, DORA GOLDMAN, ANNE MORRIS, TERESA TALIERCIO and DOROTHY NIEMITZ, on behalf of themselves and all other persons similarly situated,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

ORDER TO SHOW CAUSE AND TEMPORARY RESTRAINING ORDER

77 CIV 472

Upon the complaint previously served herein and upon the annexed affidavits of Harvey Shapiro, M.D., Walter Schwartz, M.D., Anne Morris, Teresa Taliercio, and Andrew Zweben, it is

ORDERED that the defendants PHILIP L. TOIA, ROBERT P. WHALEN, PETER GOLDMARK and HUGH L. CAREY show cause in Room 619 of the United States Courthouse, located at 40 Centre Street, New York, New York, on the day of February, 1977, at o'clock or as soon thereafter as counsel can be heard, why an order should not issue:

1. Granting a preliminary injunction pursuant to Rule 65(a) of the Federal Rules of Civil Procedure (a) enjoining defendants, their agents, servants, employees, attorneys, and those persons in active concert and participation with them, from imposing further reductions in Medicaid

reimbursements for plaintiffs' care in nursing homes and from providing reimbursements at levels below those established prior to the illegal "freeze" of 1976; and (b) directing said defendants, etc., to provide reimbursements for plaintiffs' care at the highest of the following, pending adjudication of the merits herein:

1. 1975 rates;

2. proposed 1977 rates; or;

3. rates calculated by defendants, the Department of Social Services or the Department of Health, or any other responsible official of the state or its political subdivisions, based on minimum patient care standards imposed by law, regulation, or otherwise used by said official.

IT IS ORDERED that pending further hearings of this matter, the defendants, their agents and their employees be and hereby are temporarily restrained from providing reimbursement to nursing homes at which the plaintiffs reside at levels below those established prior to the illegal "freeze" of 1976.

IT IS FURTHER ORDERED that security pursuant to Rule 65(c) of the Federal Rules of Civil Procedure be waived.

IT IS FURTHER ORDERED that service of this order and the annexed affidavits made upon the defendants or their attorneys on or before p.m. on the day of February, 1977, shall constitute good and sufficient service.

Done and ordered at the United States Courthouse, 40 Centre Street, New York, New York, on this day of February, 1977, at p.m.

UNITED STATES DISTRICT JUDGE

STATE OF NEW YORK)
COUNTY OF BRONX) SS

Harvey Shapiro, M.D., being duly sworn deposes and says:

1) I am the Medical Director of Beth Abraham Hospital, Bronx, New York. I make this affidavit in support of the plaintiffs' application for a temporary restraining order and a preliminary injunction in the case of Bulla, et al. against Toia et al.

2) I have been the Medical Director at Beth Abraham Hospital for two years. Prior to that time, I was the Medical Director of the emergency room at Montefiore Hospital and Medical Center for four years. I am an Assistant Professor of Medicine at the Albert Einstein College of Medicine and also an Associate Attending Physician in the Department of Medicine at Montefiore Hospital and Medical Center.

3) I have reviewed the reductions in staff and services demanded by the Department of Health for Beth Abraham Hospital. These cuts reflect a total lack of awareness of the medical conditions and needs of the patients at Beth Abraham.

4) Due to previous cuts in the income of Beth Abraham, the staff has been reduced to a number barely sufficient to provide the care and services required to maintain the health of the patients.

5) Any further staff reductions would result in a disaster. The health of every patient would be threatened. Inevitably the death of many would result.

Harvey Shapiro, M.D.

Sworn to before me this
7th day of February, 1977

IRIS W. KING
Notary Public, State of New York
No. 03-4606225
Qualified in Bronx County
Commission Expires March 30, 1977

BEST COPY AVAILABLE

STATE OF NEW YORK)
COUNTY OF BRONX) SS

Walter Schwartz, M.D. being duly sworn deposes and says:

1) I am the Attending Physician at Beth Abraham Hospital, a Skilled Nursing Facility, in which several of the name plaintiffs in Bulla, et al. against Toia et al. are patients. I am personally responsible for the supervision of 250 patients. I make this affidavit in support of the plaintiffs' application for a temporary order and motion for a preliminary injunction.

2) After completion of medical school, I served as the Director of the Westchester County Nursing Home at Grassland for two years. Since 1967, I have been a physician at Beth Abraham Hospital.

3) The patients at Beth Abraham Hospital require comprehensive medical and nursing services for treatment of neurological, cardiac, renal, pulmonary and other health problems.

4) At present the number of staff persons of this facility is barely sufficient to deliver the care and services needed by our patients.

5) For example, each physician at Beth Abraham has sixty patients requiring virtually daily attention. If any physician is ill or on vacation, the remaining physicians must attend the absent physician's patients. This stretches our staff to its present limits. Any reduction in the number of physicians would leave patients without medical attention.

6) I have reviewed the Department of Health's recommendations for reductions in staff and services at Beth Abraham. These recommendations are ill considered and completely impossible to effectuate consistent with minimum standards of patient care.

7) The recommendations require the firing of 7 of the 9 full time physicians at Beth Abraham, 8 of 11 nursing supervisors, 30 of 228 nursing aides, 19 of 52 housekeeping personnel (the staff of 33 in housekeeping is supposed to include operators for seven elevators which patients are not permitted to operate), 3 of 7 laundry employees, 13 of 17½ social work positions and other personnel in the full time service and leisure time activities departments. The Department also demands that Beth Abraham reduce 66 Registered Nurses to less skilled Licensed Practical Nurses positions.

8) These cuts will leave Beth Abraham Hospital hopelessly understaffed in every one of these service areas. The total effect on the health of the patients will be catastrophic.

STATE OF NEW YORK)
COUNTY OF BRONX) SS

9) A nursing home is an integrated unit. Every service area contributes vitally to the health of the patient. Unless the patient rooms and hallways are not properly and promptly cleaned, the patients will undoubtedly develop nosocomial infections which will threaten their lives and require increased medical and nursing attention. Similarly, if patients are not turned and removed from their beds frequently, they will develop decubiti which will require still greater nursing and medical care. While every employee of a nursing home may not be a skilled professional, every function without exception is vital to the health of the patients cared for in the home.

10) In conclusion, the staff composition demanded by the Department of Health will result in death of many Beth Abraham patients and hopeless deterioration in the health of many others. Already, to accommodate the Hospital's reduced income, the Administration has been forced to reduce services to a level I consider dangerous and threatening to the health of many patients.

Walter Schwartz, M.D.

Sworn to before me this
7th day of February, 1977

IRIS W. KING
Notary Public, State of New York
No. 03-4608225
Qualified in Bronx County
Commission Expires March 30, 1977

AFFIDAVIT

STATE OF NEW YORK)
ss.:
COUNTY OF BRONX)

ANNE MORRIS, being duly sworn, deposes and says:

1. I am one of the plaintiffs in the within action and I make this affidavit in support of plaintiffs' action for a temporary restraining order and preliminary injunction.

2. I am a skilled nursing patient at Beth Abraham Hospital. My floor is 4 BR. There are 36 or 37 patients on our floor, including 14 men, all of whom require full care. That is, they need to be dressed, and lifted out of bed. Several need to be fed since they are unable to do so themselves. These needs are in addition to their nursing needs.

3. Because of the cuts already made, we have only one orderly and two aides on our floor from 7:00 a.m. to 3:00 p.m. From 3:00 p.m. to 11:00 p.m. there are only one aide and one orderly on the floor. From 11:00 p.m. to 7:00 a.m. we have only one aide on the floor. During this time we share an orderly with two other floors. Occasionally because of staff cutbacks a Registered Nurse has to split duty on two floors.

4. There have been many other cutbacks made in our home to save money. There is now only one porter to keep three or four floors clean. After 4:00 p.m. there is no one to operate the elevators so that the patients, who are not allowed to operate the elevators themselves, cannot go to religious services, recreation or other activities after that time.

5. Since last January our lives in this home have changed dramatically. Until then this was a nice place; now, because of all the cutbacks and firings, the atmosphere here is miserable.

Anne Morris

ANNE MORRIS

Sworn to before me this
day of February, 1977.

IRIS W. KING
Notary Public, State of New York
No. 03-4608225
Qualified in Bronx County
Commission Expires March 30, 1977

NOTARY PUBLIC

AFFIDAVIT

STATE OF NEW YORK)
COUNTY OF BRONX)ss.:

TERESA TALIERCIO, being duly sworn, deposes and says:

1. I am one of the plaintiffs in the within action and make this affidavit in support of plaintiffs' motion for a temporary restraining order and a preliminary injunction.

2. I am a skilled nursing patient at Beth Abraham Hospital. Since January, 1976, the health needs of the patients at Beth Abraham have become more serious. During this period, and particularly beginning around November, 1976, the staff at Beth Abraham has been severely reduced.

3. There are 36 seriously ill patients on our floor, 6 BR. Of these 14 or 15 need total care, that is they require feeding, dressing, bathing, in addition to their nursing needs.

4. We used to have three aides, two orderlies and one Registered Nurse on our floor from 7:00 a.m. to 3:00 p.m. Now we often have only two aides and one orderly in addition to the Registered Nurse. Three people are insufficient to feed everyone and get them bathed, dressed and out of bed, and attend to their nursing needs.

5. From 3:00 p.m. to 11:00 p.m. and from 11:00 p.m. to 7:00 a.m. we used to have a total of four aides and orderlies besides the Registered Nurse. Now we have one aide and one orderly from 3:00 p.m. to 11:00 p.m., and one aide and an

orderly we share with two other floors from 11:00 p.m. to 7:00 a.m.

6. This number of aides and orderlies is insufficient to do the work required which includes feeding dinner, getting patients back into bed, turning them regularly, bringing bed pans, changing bed linen and administering medication.

7. The new cutbacks demanded by the Department of Health are intolerable. They would require an average reduction of one aide per floor for every shift. This conflicts with the Department's own recommendation, made in 1975 that Beth Abraham hire 63 more Registered Nurses in order to fulfill the requirements of state law. Those nurses were never hired, yet now the Department asserts that over 30 aides and nearly 8 supervisors can be fired.

8. These cuts would endanger the health of every patient in our home. Since there is already only one aide or orderly on the floor during some shifts, it is impossible to think of removing that aide. Already many necessary tasks remain undone.

9. Many patients on our floor need to be turned in bed by the floor personnel. Most of these patients require two people to turn them. Since there is generally only one aide on the floor from 11:00 p.m. to 7:00 a.m., this cannot be done. Although I myself need assistance to turn, I no longer call for help because I know there are not enough aides for the other patients.

10. I understand that the defendants have demanded still more cuts on the staff and services of our home. It is unthinkable that any more staff should be let go since there is already not enough staff to assist the patients.

TERESA TALIERCIO

Sworn to before me this
day of February, 1977.

IRIS W. KING
Notary Public, State of New York
No. 03-4603225
Qualified in Bronx County
Commission Expires March 30, 1977

Iris W. King
NOTARY PUBLIC

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JOSEPH BULLA, ANNY ALTMAN, NATALIE WARTENBERG, SIGMUND RINGER, DORA GOLDMAN, ANNE MORRIS, TERESA TALIERCIO and DOROTHY NIEMITZ, on behalf of themselves and all other persons similarly situated,

Plaintiffs,

-against-

PHILIP L. TOIA, as Commissioner of Social Services of the State of New York, ROBERT P. WHALEN, as Commissioner of Health of the State of New York, PETER GOLDMARK, as Director of the Budget of the State of New York, and HUGH L. CAREY, as Governor of the State of New York,

Defendants.

77 CIV 472

AFFIDAVIT

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

ANDREW P. ZWEBEN, being duly sworn, deposes and says:

1. I am the attorney for the plaintiffs in the above-entitled action and make this affidavit in support of plaintiffs' motion for a temporary restraining order and a preliminary injunction.

2. On January 27, 1977 I was notified that the Bayside Gardens Nursing Home, 214 Place, Bayside Queens, was closing on the following day. I spoke with Dr. Warren Toff, Deputy Commissioner of the Department of Health and Mr. Michael Duckman, operator of the Bayside Gardens home.

3. Bayside Gardens was being closed because the Internal Revenue Service had placed a lien on the home's Medicaid payments and a levy against the home's bank account.

These actions were taken to recover monies owed to I.R.S. by the home which had failed to pay $80,000.00 in withholding taxes.

4. Michael Duckman informed me that he had withheld the taxes because he was unable to operate his nursing home at the inadequate Medicaid reimbursement rate established by the defendants herein.

5. Dr. Toff confirmed the fact that Mr. Duckman could not operate at the current reimbursement rate established by the defendants. That rate is presently $37.44. As of January 1, 1977 the rate is $39.07.

6. Dr. Toff informed me that there were at least three patients in Bayside Gardens who were moribund and were not expected, by their physicians or those of the Health Department, to survive an attempt to transfer them to another nursing home.

7. The actions of the defendants which has already led Bayside Gardens to the brink will force the closing of nursing homes all over the State of New York.

8. The tragedy of Bayside Gardens is likely to be repeated all over the state, requiring the transfer of vast numbers of nursing home patients to those facilities which survive. This wide-scale transfer will undoubtedly result in the death and deterioration of a large number of patients. It will certainly cause widespread misery as lives are uprooted and friendships destroyed.

9. As related in the second supplemental affidavit of Mitchell Waife, sworn to on January 31, 1977, the Loretto Rest Nursing Home of Syracuse, New York is "already three months behind in its mortgage payments to the State and is in default to many of its vendors." (Aff. of M. Waife, p. 3) In addition Loretto is presently unable to meet its payroll of February 17.

10. In addition, the Onondaga County Department of Social Services has advised Loretto that Loretto now owes the county the difference between the rate paid for November and the reduced rate established by the defendants. The Department has advised Loretto that unless this $95,000.00 debt is paid by mid-February, its Medicaid money will be withheld.

11. The reduced reimbursement rate will also likely result in the closing of the Plaza Nursing Home in Syracuse, New York (see Affidavit of Edward Leone, Ex. H to Affidavit of M. Waife).

12. These closings and the others which can reasonably be expected will result in inestimable misery for the plaintiffs. The transfer of elderly patients from one institution to another involves a substantial risk to their lives and health. A plethora of research studies have established that the rate of death of these patients increases

markedly when they are transferred.[1] In addition to death, the health of those patients who survive can be expected to deteriorate because of the transfer and the radical change in environment.

13. Even in those homes which manage to remain open, the level of services will be reduced to a level which would endanger the lives of the patients.

14. In its response to the Department of Health, Beth Abraham Hospital stated its belief that "were the cuts to be instituted at Beth Abraham Hospital there would be significant numbers of patient deaths directly attributable to these proposed staffing changes." (Ex. B to Affidavit of M. Waife, p. 1-2)

15. In its response, Mohawk Valley Nursing Home of Ilion, New York, stated that the reductions:

> ...would reduce the level of patient care to the warehousing of human beings. We cannot, and will not, tolerate Nursing Home

---

[1] For detailed studies of the causes and effects of transfer trauma, see Blenker, *Environmental Change and Aging Individuals*, GERONTOLOGIST, (June 1967); Bourestom and Pastalan, Relocation Reports I-III, for the Institute of Gerontology, University of Michigan - Wayne State University (1974); Kasteler, *Involuntary Relocation of the Elderly*, GERONTOLOGY (1968); Killian, *Effect of Geriatric Transfers on Mortality Rates*, SOCIAL WORK (January, 1970); Markus, Blenker, Bloom and Downs, *The Impact of Relocation upon Mortality Rates of Institutionalized Aged Persons*, 26 JOURNAL OF THE AMERICAN GERONTOLOGICAL SOCIETY (1963); Yawney and Slover, *Relocation of the Elderly*, SOCIAL WORK (May 1973); Menkoff and Aldrich, *Relocation of the Aged and Disabled: A Mortality Study*, JOURNAL OF THE AMERICAN GERONTOLOGICAL SOCIETY (1963). See also, *SUBCOMMITTEE ON LONG-TERM CARE OF THE SPECIAL COMMITTEE ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY*, S. REP. NO. 93-1420, 93d Cong., 2nd Sess. 18, n. 19 (Dec. 19, 1974).

> residents being forced to lay in their own urine and feces because nursing time is not available to promptly care for them. The decubiti caused by this neglect would require further nursing time leading to additional neglect. This multiple compounding of problems is obvious.
> (Exhibit D, to Affidavit of M. Waife, p. 3)

16. The administration of the Margaret Tietz Center for Nursing Care warned the Department of Health that:

> Any reduction in staff rendering direct patient care would prevent the delivery of safe, humane and skilled care to our patient population.
> (Exhibit C to Affidavit of M. Waife, p. 3)

And the Director of Nursing of the Sephardic Home for the Aged informed the Department of Health that:

> If I were to implement the substantial cuts in the Nursing Staff recommended by the Hearing Board, I feel the consequences of this act would be devastating to those whose lives have been entrusted to us. If our present standards of care are diluted by the State Board's cuts in personnel, I feel that chaos will be the final result.
> (Exhibit E, of second attachment to Affidavit of M. Waife, p. 1)

17. Attached hereto are affidavits of Drs. Walter Schwartz and Harvey Shapiro of the Beth Abraham Hospital. It is the opinion of both of these physicians that the reductions in total services at Beth Abraham Hospital demanded by the defendant New York State Department of Health

will result in the death of many patients and the deterioration of the health of many others.

18. It is plain from these comments, and the annexed affidavits of Teresa Taliercio and Anne Morris that the reductions in staff demanded by the defendants will result in a horrifying decrease in plaintiffs' care, a deterioration of health and possibly the death of many members of the plaintiff class.

19. The latest determination of the number of nursing personnel required by the nursing homes of New York were made pursuant to a standard which conflicts with that required by the Health Code, 10 N.Y.C.R.R. §731.2(c)1, which requires that a home have on duty sufficient numbers of registered nurses, licensed practical nurses and nurses aides to provide a combined average of one hour of nursing care to each self-care patient, two hours to each partial self-care patient, and four hours to each patient requiring full care for every 24-hour period.

20. The Department of Health analyses of the staffing patterns of the nursing homes do not reflect the health care needs of the plaintiffs.

21. The rating and reimbursement system established by the Department does not consider the intensity of care required by individual patients in the affected nursing homes.

22. These reductions were enacted without notice being given to the plaintiffs. Nor were the plaintiffs

offered an opportunity for a hearing to contest the reductions in their medical assistance benefits.

23. Defendants' answer to the complaint in the case of New York Association of Homes for the Aged, Inc. against Toia admits that the Medical Advisory Committee has not met in over one year and was not consulted about the adoption or implementation of the new reimbursement system (Def. Ans. ¶35).

24. The second supplemental affidavit of Mitchell Waife, submitted in the case of New York Association of Homes for the Aged et al against Toia et al, 76 CIV 5113, is incorporated herein by reference.

25. On February 7, 1977, at approximately 12:10 p.m., I informed the Attorney General of New York, counsel for the defendants herein, that an application would be made on February 8, 1977 at 4:30 p.m. for a temporary restraining order and an order to show cause why a preliminary injunction should not issue.

26. This motion has been brought on by order to show cause because the plaintiffs' health is in imminent danger due to the impending closing of several nursing homes and the serious reductions in nursing care and services caused by defendants' actions.

ANDREW P. ZWEBEN

Sworn to before me this
day of February, 1977.

NOTARY PUBLIC

2 Copies Received
March 25, 1977
4:45 P.M.
Louis J. Lefkowitz
Attorney General
Attorney for Appellees
By George D. [illegible]
(3) Assistant Attorney General.